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LATEST ADVANCES IN ALLERGY—SEE PAGE 23

IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

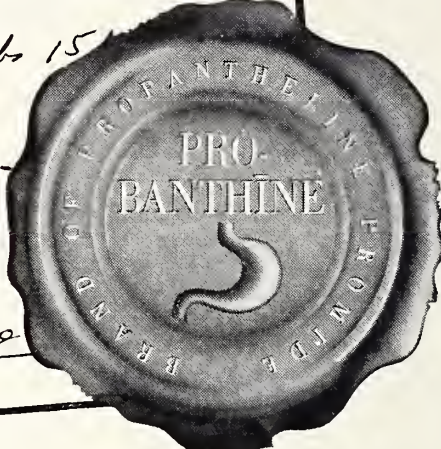
			
			<p>ENDOCRINE DISORDERS IN CHILDREN</p> <hr/> <p>SEE PAGE 35</p>

JAMES H. SEARLE, M.D.
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Research in the Service of Medicine



Illinois Medical Journal

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January, 1965

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AS I SEE IT FROM '360'

By ROBERT L. RICHARDS
Executive Administrator

YOUR RIGHT TO KNOW—IN DETAIL!

WHEN THE GENERAL ASSEMBLY OF ILLINOIS meets later this year, you as physicians of this state will require detailed reporting of the legislative decisions affecting medicine generally and your practice in particular. Even before the session begins, you will want to be aware of the important measures that will be considered.

Although newspapers, radio and television will keep you informed on general problems such as taxes and re-districting, you may have to look very closely at these media to find detailed comment on legislation affecting the medical profession.

To keep you informed of these matters—in detail—the ISMS Legislative Committee is providing you with special, detailed information through two vitally important sources:

1. The "Legislative Listening Post" which appears every month on the first page of the Illinois Medical Journal; and
2. The weekly newsletter "On the Legislative Scene" which is mailed directly to your home.

By the time this column is read you should have received the first of the legislative newsletters along with a business reply card query form. On this card you should indicate that you wish to receive "On The Legislative Scene" regularly from now on. If you forgot to make this indication don't fail to let us know so that your name can be added to the mailing list.

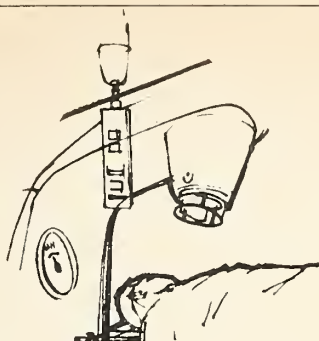
In addition to these methods of communicating the legislative picture to you throughout the succeeding six months, the chairman of every county society legislative committee will receive special letter communications stating the position of the State Medical Society on the bills of medical interest. You can depend upon him to discuss these bills at your county medical society meetings.

The secretary and president of your society, as well as your bulletin editor, will receive similar information. It is our hope that they will keep you informed by timely presentations and editorial comment.

Our committee and staff do not prepare comment on all bills introduced at a session. If, however, any piece of legislation should be of interest to you, don't hesitate to contact either the headquarters office in Chicago, or the Springfield Regional Office. At least a copy of the bill will be secured and mailed to you.

These are the ways in which the State Society hopes to keep its members informed on the measures being considered by the General Assembly. In the interests of your medical colleagues who devote much volunteer effort to the legislative interests of organized medicine, of your fellow citizens, and of your own ability to better serve your patients, we hope that you will take advantage of these special communications services.

MEDICAL PROGRESS



HARVEY KRAVITZ M.D./editor

DEVELOPMENTS IN ALLERGY in recent years have been mainly along lines of basic considerations. Although diagnosis and therapy have not kept pace with these researches it is fair to hope that such effects will follow, since in general it is to be expected that the one must precede the other. It is obvious that a complete

report of this topic would require hundreds of pages. It is, therefore necessary to confine this presentation to several selected items and to only the highlights of each item.

Penicillin Allergy

PROGRESS IN ALLERGY

PART 1 OF A THREE-PART SERIES

*Samuel M. Feinberg, M.D., Raymond G.
Slavin, M.D. and Alan R. Feinberg, M.D.
/chicago*

From the Departments of Medicine, Evanston Hospital, Evanston, Ill., and Northwestern University Medical School, Chicago, Ill.

Part of the work described in the manuscript was supported by Public Health Service Research Grant No. AI-04234 from the National Institute of Allergy and Infectious Diseases.

Penicillin allergy is directed chiefly along three patterns: contact dermatitis, serum sickness type, and anaphylactic or immediate reaction. The contact allergy has been largely eliminated by the ban on the use of topical penicillin products. The "serum sickness" reaction, consisting primarily of urticaria, angioedema, fever and sometimes visceral involvement, may last from a few days to as long as a year. The incidence varies from about 1 to 5%¹ in different series and the disease can occur on the first exposure. It has been generally agreed that it is not predictable by any diagnostic test, and is therefore regarded as a calculated risk.

The immediate or anaphylactic reaction is the most hazardous. The symptoms appear within moments or minutes and may consist of urticaria, asthma, and other anaphylactic manifestations or shock, and may lead to a fatal outcome. Most estimates of immediate reactions place the figure around 0.1%². Our experience with history taking in an allergy practice would lead us to believe that it is higher. Projection of statistics from surveys indicate that

there may be as many as 100-200 anaphylactic fatalities in the United States annually. On a visit to South America several years ago we were told by Brazilian physicians that anaphylactic deaths from penicillin injections are common there, enhanced by the fact that such injections could be given there by the pharmacist on the patient's request. More than half of the anaphylactic reactions occur in atopic individuals, particularly those with asthma and hay fever. Almost always the immediate reactor has had penicillin some time previously, by injection or orally, which has acted as the sensitizing dose. It is presumed that some who have not had a prior exposure to therapeutic penicillin may have been sensitized by other sources, such as penicillin in milk, or in the early polio vaccine or influenza vaccine.

Objections to the use of the skin test for penicillin allergy have been stated along four lines: 1) it is time-consuming; 2) it is unreliable; 3) it might provoke an anaphylactic reaction; and 4) it might initiate sensitization. Little need be said about the advantage of saving a life by taking an extra 15 minutes required for a test. That it might provoke an anaphylactic reaction is a possibility; however, some safeguards previously stated minimize this possibility.³ Initiation of sensitization is a possibility. The question of reliability requires some clarification. In figures presented in published and unpublished reports there is a tendency to lump the delayed (serum sickness) and the immediate manifestations in the incidence of skin tests^{4,4a}. The skin test is not expected to forecast delayed reactors, because the sensitivity is produced after the therapeutic dose. Even after the delayed reaction has been produced skin sensitizing antibodies are not a common finding. The skin test, therefore, is only of significance to detect a patient who has already developed skin sensitizing antibodies and who may be susceptible to immediate or anaphylactic reactivity.

The majority of patients whom we have seen who have had an immediate allergic penicillin manifestation had a positive skin test to penicillin. Most others do not agree with this. For example, Beatty and co-authors⁵ found 6 who reacted on skin test to penicillin in 20 patients with a history of immediate allergic reactions to this drug. DeWeck⁶ also found a low incidence of skin reaction to penicillin. Possible light on

such discrepancies may become evident in the discussion of newer developments on penicillin allergy which follow.

Penicilloyl-Polylysine: The concept that a moiety of the penicillin molecule, rather than penicillin itself, is the antigen responsible for anaphylactic manifestations and the positive skin test was approached by two groups, Levine and his associates, and Parker and his co-workers. Levine⁷ found cross reactions among some of the 7 purified degradation products of benzyl penicillin when testing contact sensitivity in the guinea pig. DeWeck and Eisen⁸ agreed with Parker and his associates that penicillin does not have the structure enabling it to conjugate with protein, as one might expect a low molecular weight antigen to require. Penicillenic acid, on the other hand has a free sulfhydryl group, enabling it to combine with proteins, and is readily formed spontaneously in penicillin solutions. Penicillenic acid is an unstable intermediate in the degradation of penicillin to penicilloic acids. Conjugates of penicillenic acid with human gamma globulin or human serum albumin in Freund's adjuvant injected into guinea pigs resulted in skin reactivity to the conjugates but not to the proteins alone. Rabbits immunized to penicillenic acid-bovine gamma globulin conjugates gave positive skin tests to the human protein conjugates.

In further studies by Levine and Ovary⁹ D-benzylpenicillenic acid was reacted with human serum albumin, gamma globulin, gelatin and poly-L-lysine. The lysine-amino group reacted best with polylysine conjugates, by precipitation in aqueous medium and gel, by passive cutaneous anaphylaxis and by specific inhibition with the haptens. In 3 out of 6 patients with a history of allergic reaction to penicillin there was a wheal and erythema reaction to the conjugates.

The principle of the use of polylysine rather than a complete protein molecule was the hope that it would not be antigenic, i.e., it would not induce sensitivity. Parker and his co-workers¹⁰ were unable to produce antibodies in guinea pigs injected with penicilloyl-polylysine. They skin tested with penicilloyl-polylysine a large group of subjects who had received penicillin therapy. Of the 23 who reacted to the polylysine conjugate 9 had systemic reactions to the subsequent administration of penicillin. Only

1 of the 10 reactors gave a positive skin test to penicillin. That the penicilloyl-polylysine can produce anaphylactic reactions was evidenced by the fact that 2 had a systemic reaction from the test dose. On the other hand, they found a high incidence of reliability of the test, 45 giving positive skin tests in a group of 59 with a history of allergic reactions to penicillin.

From another report some doubt can be inferred as to the reliability of the penicilloyl-polylysine test as an indicator of anaphylactic sensitivity. Rytel and his associates¹¹ made intradermal tests with this antigen on 1022 naval recruits. Of 868 who had had penicillin previously, 8.4% gave a positive test, while 3% of 125 who had never had penicillin reacted. In the penicillin-treated group 43 had had previous allergic episodes, 3 of which were anaphylactic. In 35% of these the skin test was positive, while in those who had had no systemic reactions 6.8% were positive.

In the most extensive and most recent report on testing for penicillin hypersensitivity with penicilloyl-polylysine in 16,239 patients Brown and co-workers^{4a} found 396 positive reactions in 1,003 (34.5%) with a history of penicillin reactions and 6.2% in 12,559 patients with a negative history. There was a higher incidence of reactors in those with a negative history in the associated clinics in the study as compared with the St. Louis group. For the purpose of this study the error was again made in combining in one group without distinction those who had a history of immediate manifestations and serum sickness reactions. Conclusions drawn from such a study cannot be completely valid.

A most recent critical report by Siegel and Levine^{11a} indicates that patients allergic to penicillin may show positive skin tests to benzyl penicillin, yet fail to react with penicilloyl-polylysine. They recommend that both products be used in testing.

DeWeck¹² also recounts that of 263 patients with a history of penicillin allergy 81% showed a positive immediate intradermal reaction to penicilloyl-polylysine. He adds the following: Penicillanic acid occurs readily in neutral or acid solutions of penicillin, and is present as trace impurities in dry crystalline penicillin. All penicillins, whatever their side chains, will be converted to penicillanic acid but at different rates, depending on various conditions, and

thus the amount of penicillenic acid to which any individual might be exposed can vary materially. The free penicillanic acid may be present in sufficient quantity before injection or is split off after injection. On this may depend the severity or perhaps even the likelihood of an anaphylactic reaction.

These facts may explain certain experiences. It is well known that penicillin solutions, on aging or heating, lose their antibiotic potency but not their antigenicity. In fact, in the light of these findings there is reason to believe that they may become more antigenic under these conditions. Perhaps our own experience of obtaining a high incidence of positive skin tests with penicillin solutions on those who previously had systemic reactions may be due to the fact that our solutions happened to have a high content of penicillenic acid.

Hemagglutinins: In 1958 Ley and associates¹³ reported a hemagglutination reaction with penicillin. The first observation was accidental. It was noted that blood to which penicillin was added for preservation sometimes agglutinated by the addition of another serum or its own serum. From this they developed the technic of penicillin antibody hemagglutination test. The test as originally described as follows: A mixture of 4 ml of whole blood and 4 ml of Alsever's solution is added to a vial containing 200,000 units of penicillin G and incubated for 1 hr at 37°C. The red blood cells of an aliquot of the suspension is washed 3 times with isotonic saline. This is made up to a 4%-10% suspension in saline, and is examined for agglutination in a test tube or on a slide. Inhibition of the reaction was also demonstrated by adding penicillin previously to the serum. In 2,000 blood specimens 25 reacted. All had had penicillin previously, but only a minority had had allergic reactions.

The hemagglutinating antibody was studied further by Watson and co-workers¹⁴. They found that the sera from persons receiving large doses of penicillin produced agglutination of human erythrocytes sensitized with penicillin. The agglutinating factor was heat stable. In the presence of complement some of the strongly positive sera produced hemolysis of red cells. Addition of penicillin to the serum inhibited the hemagglutination, but this effect could be reversed by the addition of penicil-

linase. Hemagglutinating serum had no inhibiting effect on the anti-bacterial action of penicillin. Starch-gel electrophoresis of agglutinating sera showed the factor to be present in the pre-albumin zone. No precipitating bands with penicillin could be obtained. Disappointing was the finding that the sera of patients sensitive to penicillin did not have the agglutinating factor.

On the other hand, from Vaughan's laboratory¹⁵ the conclusion is reached that there is a higher percentage of hemagglutination in penicillin reactors than in non-reactors. In a study on hemagglutinating antibodies in penicillin allergy VanArsdel and his associates¹⁶ summarize that "Of 140 patients with histories of penicillin allergy, the association of hemagglutination with the more severe forms of allergy was striking, but not absolute."

Intolerance to Cow's Milk

Since milk is one of the most common foods and since intolerance to it could affect a significant proportion of adults and children, it is necessary that its presence and mechanism be recognized. Three types of untoward reactions to cow's milk are present. That due to fat intolerance needs little clarification and need not be discussed here. The use of skimmed milk instead of whole milk is the usual solution.

Allergy to milk proteins has been recognized for many years but additional manifestations are just being noted. The incidence of milk allergy has needed further clarification. Mueller et al¹⁷ have attempted to carry out a study to determine the true incidence in a general population. Many difficulties were encountered which might be solved in future studies. Out of 199 babies they found 28 who had definite or probable evidence of atopy. Although a high percentage were reported as showing a positive skin test to milk or its components, only two of these were proven conclusively to be allergic to milk by its repeated avoidance and use. Only 15 of the 28 atopic children had an immediate family history of allergy. Because of these data and other findings they could not consider it wise or justifiable to feed potentially allergic infants a milk substitute from birth as advocated by Johnstone and Glaser¹⁸.

Heiner and associates¹⁹ have described a syndrome of chronic respiratory distress, poor growth, gastrointestinal symptoms, evidence of

allergy, iron deficiency anemia and pulmonary hemosiderosis accompanying the presence of multiple precipitins to cow's milk in the patient's serum. This study was stimulated when precipitins to a crude culture filtrate of *Mycobacterium tuberculosis* were discovered in the serum of a child with a puzzling illness. Other antigens of mycobacteria were negative and this differed from their previous experiences. Bovine serum protein in the media was found to be the agent reacting. Further studies employing gel diffusion technique showed a number of precipitins to cow's milk. This finding stimulated them to study sera of 3,484 patients (including 1,284 patients in an addendum). Thirty-three of these patients had multiple (5 or more) precipitin bands on gel diffusion. Of the original group of 8 reactors, 7 were studied in detail and all had most of the symptoms of the syndrome mentioned earlier. Hemoglobin varied from 2.9 gms % to 11.3 gms %. The sera contained 7 to 14 bands in the agar diffusion test on original study. From zero to 9 bands were found later after avoidance of milk and hemoglobin increased to 10.0 to 14.8 gms %. Of interest is the fact that all of the 7 patients had a positive intradermal test to whole milk, whereas scratch tests to milk antigens were negative.

Holland and associates²⁰ examined the sera of 1,618 infants and children and found 87 showing precipitin bands. In contrast to the previous study the number of bands were fewer than 6 in all cases. Precipitins to bovine serum albumin and bovine gamma globulin as found in milk occurred most frequently. They found that in this group of patients demonstrating precipitins there was an uncommonly high incidence of recurrent respiratory tract disease, failure to thrive, anemia and hepatosplenomegaly as compared with a control group of hospital patients. Removal of pasteurized milk from the diet of 24 of these patients resulted in clinical improvement in 22. There was not a particularly high incidence of allergy in the families of the children with precipitins.

Peterson and Good²¹ used various immunologic techniques to detect antibodies to cow's milk proteins and attempted to assess the significance of these antibodies. Sixty-seven percent of 288 sera tested had an hemagglutination titer of 1:10 or more and 25% of the sera tested (170)

had detectable precipitin. Most of the cases were children and many were tested because of suspected milk allergy. A majority of the children with recurrent or chronic pneumonia had titers of milk antibody considerably higher than normal. A few of the patients were skin tested to milk but these tests did not correlate with other tests.

Parish²² has been a leading advocate of the hypothesis that cot-deaths (crib deaths) are caused by unrecognized hypersensitivity to, and aspiration of, cow's milk. These are sudden unexpected deaths in apparently healthy infants during sleep. He has presented evidence of the existence of antibodies in the sera of those who have died. He has demonstrated a similar type of reaction in lightly anesthetized guinea pigs. Peterson and Good were unable to detect antibody in the sera of 6 children who suffered crib-deaths. Gold and Adelson²³ studied antibodies in the serum of infants dying from known and unknown causes, compared them with the antibodies found in well infants, and found no significant differences. The tanned cell hemagglutination test was the major technique, while in some instances passive cutaneous anaphylaxis tests were made. Kaufmann, Lantz and Bürgin-Wolff²⁴ feel that the syndrome of sudden unexpected death that sometimes in the past has been called "status thymicolymphaticus" may be due to micro-aspirations of cow's milk. They present a case in which post-mortem and serological findings are fully compatible with the diagnosis of anaphylactic shock of the lungs due to cow's milk. Gunther et al²⁵ examined the sera of infants from birth for the presence of hemagglutinating antibodies and observed that one in ten infants develops high titer of circulating antibodies in response to ingested milk by the 7th and 10th day. Sheehan and Glaser²⁶ attempted to correlate clinical milk sensitivity with agar gel diffusion and tanned cell hemagglutination techniques and were unable to relate the results with clinical sensitivity. Approximately 50% of the sensitive control groups had elevated hemagglutination titers. Larose et al²⁷ found a similar distribution of hemagglutinating titers. Friedman et al^{27a} studied sera obtained at autopsy from 100 children with unexpected deaths, and compared these with control sera for milk antibodies. They found that

a high percentage of sera of children who died at 2 to 4 months of age had relatively high hemagglutination titer compared with controls. It is probable that in crib-deaths more than one etiology is present and that in at least some cases milk hypersensitivity might play a role.

Heiner²⁸ finds that precipitins are rare in infants fed solely heat-processed formulas, although some have symptoms of milk sensitivity and other laboratory findings that disappear on removal of milk from the diet. It may be that the antibody is being neutralized by the steady intake of milk. He recommends that two serum specimens for testing be secured, one during milk intake and another 2 weeks after milk is removed from the diet.

Heiner, Wilson and Lahey²⁹ point out the difficulties of diagnosing milk sensitivity, especially if the onset of the symptoms is delayed and prolonged. There may be no laboratory test that is regularly reliable for detecting this type of delayed hyperreactivity, but carefully controlled feeding tests should enable one to demonstrate this. The same authors³⁰ describe one type of this sensitivity that they were able to diagnose by indirect laboratory tests. Four infants with hypochromic microcytic anemia due to chronic gastrointestinal blood loss also had multiple precipitins to cow's milk. By radioisotope techniques they could demonstrate blood loss into the stool sufficient to cause the anemia when the infants were fed cow's milk. When soybean milk was substituted the bleeding stopped.

Various attempts have been made to determine the proteins in cow's milk responsible for sensitivity. By precipitin tests and passive cutaneous anaphylaxis in the guinea pig Saperstein and Anderson³¹ have demonstrated that only the bovine serum albumin and bovine gamma globulin are partially or wholly inactivated by heat processing and, therefore, sensitivity to other components such as lactalbumin or casein would be unaffected by the processing of milk. Cole and Dees³² obtained similar results in comparing antigenicity by anaphylaxis in guinea pigs. Goldman et al³³ have carried on an extensive cooperative study on a large number of clinically milk sensitive patients and have tested various fractions of milk to determine which were important. Most of the patients were those showing the conventional

atopic symptoms of rhinitis, asthma, atopic dermatitis and gastrointestinal symptoms. In most of them challenge with milk feeding reproduced the presenting symptom. Some symptoms occurred within the first 12 to 24 hours, while others required 2 days or more before they were discernible. The reaction lasted usually between 12 and 24 hours. The more sensitive the patient the earlier the symptoms appeared. In 45 patients tested by oral challenge with milk fractions, reactions occurred to one or more milk proteins. The incidence of reactions were: casein, 57%; bovine serum albumin, 51%; beta-lactoglobulin, 66%; and alpha-lactalbumin, 54%. Only 13% were allergic to bovine serum albumin alone. There was no correlation between the type of protein and the type of symptoms produced. In a later study Goldman et al³⁴ skin tested patients with milk and purified milk proteins. They found that strongly positive skin tests correlated with feeding tests, whereas weakly positive tests did not.

Goat's milk has often been used as a substitute for cow's milk in allergic children. Hanson and Anderson,³⁵ using immunoelectrophoretic techniques, give evidence that some of the proteins of goat's milk and some of human milk cross react with those of cow's milk.

It would appear that milk allergy is not as simple as once considered. However, in time the various syndromes may become better defined. It may turn out that the following statements are true: 1. Hemagglutination tests give no indication of the type of sensitivity discussed. 2. One type of allergy is demonstrated by precipitin tests. 3. This is distinct from the type of allergy with symptoms of eczema, rhinitis and asthma that is caused by nonprecipitating antibodies (reagin) and may be determined frequently by proper technique of skin testing and passive transfer of serum. 4. A third type of allergy may be of the delayed type similar to tuberculin sensitivity that may be demonstrated by delayed type skin tests and passive transfer with leucocytes.

The third type of milk intolerance is that due to the sugar fraction of the milk. This has been recently described more thoroughly by Dahlqvist et al³⁶. They find that there is a group of patients who have an inability to break down lactose and whose symptoms, mainly diarrhea, disappear when lactose is removed from their

diets. By obtaining biopsy specimens from the duodenum they demonstrate a deficiency of the enzyme lactase. This can also be shown by a lactose tolerance test determined by glucose blood levels after the ingestion of lactose. This must be compared with an oral glucose tolerance test to rule out faulty absorption from the gastrointestinal tract as a cause of the flat curves found in this syndrome. This syndrome is of special interest because the same symptoms may be caused by allergy to milk protein. The symptoms will subside on elimination of milk and return on readministration. However, the skin tests and other immunological tests are negative.

Methods of Antibody Recognition

Various immunologic methods for the detection of antibodies have been discovered or improved in the past few years. There are refined techniques to demonstrate and differentiate precipitin reactions. Newer methods of identifying nonprecipitating antibodies have been developed. There are indirect ways of showing an antigen-antibody reaction by identification of gamma globulin, etc. Antibody or antigen may be labeled. Other techniques have demonstrated antibodies by the effect of the antigen-antibody complex on a biological system. We shall attempt to describe briefly various of these newer methods; however, many details and some methods, will of necessity be omitted.

After having been neglected for many years, immunodiffusion was reintroduced by Oudin in 1946.³⁷ Ouchterlony³⁸ used a double diffusion system where both the antigen and the antibody diffuse in a gel such as agar. This technique minimizes the necessity for a great many dilutions of antigen and antibody so as to obtain the optimum proportions for maximum precipitation. It also enables a comparing of antigens and antibodies so that cross reactions and relationships may be observed. Various patterns of wells have been devised so as to enable demonstration of different types of reactions.³⁹ Visual observation of the precipitin bands is usually necessary; however, techniques using radioisotope labeling,⁴⁰ staining of proteins or precipitation of antigen-antibody conjugates, and other methods enable one to determine otherwise invisible reactions.⁴¹

Immunoelectrophoresis was first described by Grabar and Williams in 1953.⁴² A serum or other antigen to be analyzed for antibodies is placed in a well on an agar slab and current applied to the two ends so as to separate it into its fractions by electrophoresis. After adequate separation an appropriate antiserum is placed in a long, narrow trough along the separated serum or antigen and a double immunodiffusion takes place resulting in several precipitin bands forming in the agar. Twenty or more different proteins in human sera have been identified by this method. Rordam⁴³ was unsuccessful in demonstrating allergen-reagin reactions using this method. Modification of the method using some of the previously mentioned techniques of demonstrating invisible antigen-antibody complexes might provide different results.

In order to demonstrate smaller amounts of antibody various methods use agglutination of particles. Antigens are attached to these particles either chemically or by adsorption. The particles most often used are red blood cells. Boyden⁴⁴ conjugated various proteins to tannic acid-treated red blood cells and then added specific antibodies to demonstrate the reaction. Pressman, Campbell and Pauling⁴⁵ coupled proteins to red cells with bis-diazotized benzidine. Both of these methods have been extended and modified.⁴⁶ Limitations have also been recognized. Clinical applications to human allergy were at first felt to be promising but apparently have turned out to be fairly limited.

Farr⁴⁷ has labeled antigen with I^{131} , added antibody, precipitated the complex with ammonium sulfate and the radioactivity determined to indicate the amount of antigen, and hence indirectly the amount of antibody present. A similar mechanism is employed by Pruzansky, Patterson and Feinberg⁴⁸ who coprecipitated the antigen I^{131} -antibody complex with rabbit anti-human gamma globulin. Antibodies to ragweed antigen were identified in the sera of untreated ragweed sensitive subjects by this method.⁴⁹

Various other indirect methods of identifying antibody and antigen-antibody complexes are being used experimentally. Fluorescent dyes are coupled with either antibody, antigen or a heterologous anti-globulin and the site of the reaction examined under a microscope suitably equipped for fluorescence visualization.⁵⁰ Un-

der these circumstances the system acts as a stain, specifically localizing the reaction. A somewhat similar method is that using radioactive labeled proteins for the detection of cell fixed antibodies.⁵¹ Another method involves the use of ferritin-antibody conjugates as stain and identification by electron microscopy.⁵² This ingenious technique enables localization within cells of the antibody and gives useful experimental information.

Various other techniques have attempted to show the effect of the antigen-antibody reaction on the living animal or living cell. The measurement of histamine release from cells has long been used for this. This procedure takes on added importance with the development of fluorometric methods of chemical determination of histamine.^{53,54}

Other tests recognize the toxic action of the antigen-antibody complex on living tissues in tissue cultures⁵⁵ or in virus cultures as in the plaque inhibition test.⁵⁶

Degranulation of basophil leucocytes in response to the antigen-antibody complex has been described by Shelley⁵⁷ as a simple test to enable one to recognize a great many antibodies *in vitro*. It has been claimed that allergy to foods, pollens, penicillin and drugs such as aspirin may be detected by this method.⁵⁸ In penicillin allergy Katz et al⁵⁹ confirmed Shelley's findings. However, this work was done, partly at least, in Shelley's laboratory. Using a controlled technique they found that 50 per cent of their penicillin-reactor group gave a positive test, whereas only 5 per cent of the control group were positive. As has been usual in many other studies, no differentiation was made between the various types of clinical allergic reactions to penicillin. Klopstock et al⁶⁰ have reported positive tests using a modified technique in 50 patients sensitive to such diverse items as pollen, barbiturates, serum, and tuberculin. Confirmation of the great value of the test as a clinical tool has not been obtained by others.⁶¹⁻⁶³

One of the most sensitive tests for the detection of antibody and the titration of antigen is passive cutaneous anaphylaxis, known as PCA. This test was first described by Ovary⁶⁴ and utilizes the effect on the minute vessels of the skin from the liberation of vasoactive substances characteristic of the immediate allergic

reaction. This causes an increase in vascular permeability which may be demonstrated by injection of a suitable dye, such as Evan's Blue, intravenously. The guinea pig is usually employed as the test animal and antibody is injected intradermally. After an incubation period the antigen mixed with dye is injected intravenously. The dye stains the skin at the site of the intradermal injection if antibody for the antigen injected is present. Using known antibody diluted appropriately, this test is probably the most sensitive known today.⁶⁵ As little as 0.003 γ g N of antibody may be detected. One

of the main problems with this test is that it is not completely clear as to what type of antibodies elicit the reaction.⁶⁶

Passive transfer tests in man have been demonstrated for years. However, because of the danger of transmission of serum diseases, such as hepatitis, its use has been necessarily restricted. Layton et al⁶⁷ have demonstrated that a similar test using human serum may be carried out using Macaque monkeys. The skin of the monkey acted in most respects as would be expected of human skin.

Part 2 will appear in the February issue.

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EPILEPSY

Successful therapy of epilepsy requires a total treatment approach, with emphasis on drug therapy, patient rehabilitation, and treatment of associated conditions.

THERE SEEMS TO BE a great deal of reticence to make a diagnosis of epileptic symptomatology. It is easy to understand this in a patient who is so afflicted, or in his or her relatives, but it is somewhat more difficult to understand on the part of the general practitioner. I believe one reason for this is that most medical men would like to see the classical symptomatology as described in grand or petit mal seizures; however, this is not commonly found, and it is my

contention that, in attempting to diagnose epileptic symptoms, too much emphasis is laid on whether or not the symptoms are classical. It seems to me, therefore, that, before one inquires as to what is new in epilepsy, it is very important that he begin with basic concepts.

Actually, the modern era of clinical epilepsy was introduced by Hughlings-Jackson in about 1870 (3rd ref. quoted by A.J.A.). Jackson described an epilepsy as "a sudden excessive and rapid discharge of gray matter of some part of the brain, the different forms of epilepsy being due to variations in the site of the 'discharging lesion'." Said Jackson, "It is certain that there are varieties of epileptic seizures, each marked by a particular place of onset of the convulsion." From these statements, it can be seen that Jackson felt that epilepsies were all symptomatic. In 1888, Jackson, discussing the essential meaning of the concept of epilepsy, stated, "I urge strongly that the great thing as to the diagnosis of epilepsy is not the quantity of the symptoms nor the severity of the fits, but paroxysmalness. Again, loss of consciousness is not essential for the diagnosis of epilepsy; there may be defective consciousness only." If one remembers Jackson's descriptions, then he will be able to diagnose an epilepsy from the symptoms, whether classical or non-classical, common or uncommon.

There is also too much preoccupation with cause without specific treatment of the patient with the symptom. This means that many patients are either untreated or inadequately treated, simply because the physician, running through the usual tests and finding nothing helpful, succumbs to a feeling of frustration.

One word relative to semantics. Whereas

MEDICAL REVIEW ARTICLE

WHAT'S NEW IN EPILEPSY

Alex J. Arieff, M.D./chicago

formerly "equivalent seizures" was a term used to describe seizures due to stimulation of the brain giving rise to other types of seizures than classic grand or petit mal. A newer term is "psychomotor seizures". Unfortunately, however, this term is misunderstood by many lay people, as well as doctors, to mean having to do with mental aberrations, instead of "psycho" meaning psychological phenomenon or motor phenomenon, or a combination of these in the form of a seizure. Although these seizures are usually harder to treat than the classical grand mal, they, nevertheless, can be treated by some of the newer drugs, and the diagnosis of a psychomotor seizure should not give rise to a wholly-unwarranted pessimistic attitude.

There have been two excellent reviews of the literature on epilepsy in the past year (1963):— (1) by C. Ajmone-Marsan and K. Abraham and (2) by W. J. Friedlander. In addition, the journal—*Epilepsia*—is devoted solely to epilepsy. I would urge all who are interested to read these excellent articles. I have drawn briefly and freely from them.

In a review of the literature, Ajmone-Marsan points out that about one paper on epilepsy is currently being published daily, showing that a great deal of work is being done on the various aspects of epilepsy. As a result of this work, one is struck with the fact that epilepsy is not a disease but a symptom, and each patient is a problem unto himself.

Two research trends are apparent in most of the experimental papers:—One is aimed at eliciting the local intrinsic factors responsible for the seizures, and the other at the possible role of structures not yet involved in the process.

From the point of view of etiology, attention is being given to brain tumors, Western encephalitis, poliomyelitis, cerebral atrophy, multiple sclerosis, psittacosis and intestinal parasites. There is also a renewed interest in head injuries, e.g. post-traumatic epilepsy. In epilepsy beginning late in life, i.e. at least after the age of 25, trauma and arteriosclerosis appear to be the most common etiological factors. In a group of 100 unselected cases of late seizures, head trauma was found to be the second most frequent cause (12 per cent) after encephalitis (26 per cent) and before brain tumors (7 per cent). In a group of 209 cases of verified astrocytomata, 40 per cent had seizures, and in 88

cases the seizures were the first sign or symptom. Severity and extent of cerebral damage is most important as shown in a study of 739 head injuries sustained during World War II, in which post-traumatic epilepsy was treated and followed up to 15 years.

There has been further study in the area of hereditary factors and epilepsy. In studying 941 parents and siblings of 211 centrencephalic epileptics, up to 13.1 per cent had a history of seizures, as compared to 3.3 per cent in the control group. A higher percentage of the parents and siblings were found to have abnormal EEG patterns, characteristic of so-called centrencephalic epilepsy. These studies should not deter treatment.

The danger of diagnosing encephalitis as the cause of acute cerebral or CNS illness with seizures was emphasized in a report of 48 autopsies performed on children with the clinical diagnosis of encephalitis, 15 of whom had seizures; no inflammatory changes were seen.

It was interesting that Doriden (glutethimide) was responsible for an unusual number of drug-withdrawal seizures, although other drugs do also cause withdrawal seizures, such as Dilantin.

With respect to diagnosis, the EEG integrated with clinical data is still considered one of the most efficient diagnostic tools in epilepsy and related disorders. Pneumoencephalography and radioisotope studies augment our diagnostic ability. Further studies on activation by means of the EEG during sleep show that short-sleep studies may not be as effective as long-sleep studies, e.g. seven to nine-hour sleep tracings in questionable cases.

There has again been increased interest in studying the various types of seizures, such as petit mal or akinetic seizures, focal epilepsy, temporal lobe epilepsy and unusual syndromes and case reports, including epilepsy caused by reading or doing arithmetic, as well as epilepsy in which television-viewing may be the precipitating factor. It is becoming more generally accepted that almost any type of symptom, sensation, motor phenomenon, psychiatric abnormality or complaint may be a manifestation of epileptic nature, and, if this is paroxysmal, one should consider it as an epileptic manifestation.

Although many new drugs have been investi-

gated as a possible anticonvulsant agent, there is no new drug at the present time to supplant the common anticonvulsant drugs already available. This would seem to augur that before new drugs are in vogue in the United States, it will take a long time under the prevailing drug act. Perhaps this is as it should be for the sake of possible adverse reactions. Some of the new succinamides seem to be not only helpful in petit mal but in major seizures as well. The anti-malarial—Quinacrine—has been used in refractory petit mal, and has been effective in the majority of patients. There are, however, many new compounds being investigated. With our increasing knowledge, it is to be recognized that in a percentage of patients with epilepsy there are behavioral disturbances, and some of the newer, so-called tranquilizers have been used as adjuvant drug therapy with some success. Some case reports, however, are not convincing. In some cases of barbiturate-withdrawal seizures, Dilantin has been ineffective, and the intravenous infusion of urea, in addition, has helped.

Surgery in epilepsy is still being explored, and is confined mainly to temporal lobe epilepsy. There are still many problems connected with it, and it is not yet the whole answer to the problem.

In discussing rehabilitation and psychiatric aspects, the author has mentioned these factors:—(1) The patient may develop a psychological reaction to his seizures to disable him. (2) There may be a non-acceptance of his illness as a part of the patient's "denial of illness". (3) The attack, itself, may be a psychiatric problem. (4) The post-ictal state may present psychiatric abnormality, so that the clinician forgets the cause of the particular psychiatric state. (5) There may be associated psychiatric abnormality, such as immaturity, mental deficiency, obvious organic brain disease with or without deterioration, tumor, actual psychosis or other personality disturbances, having nothing to do with the epilepsy per se. (6) Mental deterioration is commonly considered a necessary part of epileptic disorder, but this is actually rare and occurs in less than five per cent of extramural patients.

With regard to the various aspects of disabil-

ity, many families and patients consider the epilepsy to be the most important symptom causing disability. (1) Although seizures may be disabling, they are disabling in less than 20 per cent of the affected population. (2) Social stigma and family reaction may disable the patient. This may require a great deal of education. (3) Failure to recognize and/or treat associated medical conditions, or relating all other conditions to the epilepsy may be disabling. (4) Disability may be iatrogenic. When a physician institutes proper diagnostic procedures and puts the patient on medication, treatment should not stop there, but rather either be continued by this particular physician or carried out by whomever or wherever the patient is referred. Followup is necessary to see that this is carried out. This occurs particularly in the institutional practice, and may be a serious handicap to the patient, in that much money is spent in doing many procedures, but it all goes to nought when the patient leaves the institution and returns to the treating physician who barely has sufficient information.

Summary and Conclusions

Some of the literature has been reviewed.

Although much investigative work is underway regarding causes and general knowledge of the epileptic symptomatology, one should not neglect what is known about diagnosis, etiology and treatment. The diagnosis of epilepsy should be made mainly on the paroxysmalness of the symptoms, as discussed by Hughlings-Jackson. With regard to successful treatment and rehabilitation of the patient with an epilepsy, the whole patient must be studied and treated.

What is old, therefore, is still new. Complete treatment of the patient with an epilepsy includes drug therapy, the patient's acceptance of his illness, the treatment of associated conditions, and, in certain cases, neurosurgical removal of the "firing" cortical focus.

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THIS DISCUSSION WAS DESIGNED as a schematic clinical orientation of common problems in pediatric endocrinology, and has been a part of the teaching curriculum for general practitioners, residents and graduate nurses at the Children's Memorial Hospital. We have emphasized the importance of an adequate history and physical examination for a differential diagnosis of these problems, and have stressed with the aid of tables and charts the relative frequency and percentage of endocrine versus non-endocrine conditions when patients present themselves to the physician. Little attempt was made to outline detailed descriptions of all clinical syndromes, and references other than to standard textbooks of endocrinology were kept to a minimum.¹⁻³

Most endocrine conditions in children present clinically as problems in Weight, Height or Sex, either alone or in various combinations. It is our purpose to relate these syndromes to the endocrine gland(s) which may be involved, and indicate the frequency or relative percentage of endocrine or non-endocrine aspects of each of these factors (Chart 1). Following this we will discuss each of the major categories in a similar manner.

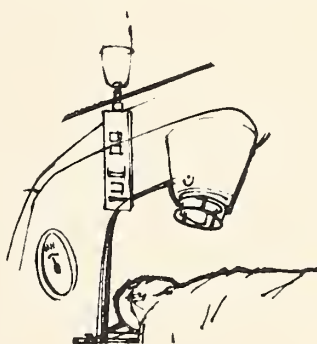
Problems in Weight

I. Obesity (Chart 2)

A. Endocrine Factors

1. *Hypothalamus*. Some very rare types can occur with defects or disturbances of the hypo-

MEDICAL PROGRESS

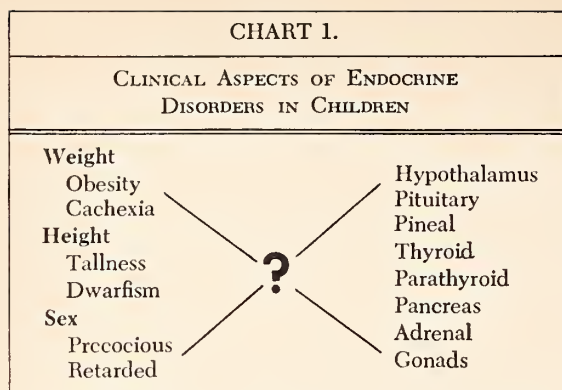


CLINICAL ASPECTS OF ENDOCRINE DISORDERS IN CHILDREN

Matthew M. Steiner, M.D./chicago

Associate Professor of Pediatrics, Northwestern University Medical School and Attending Physician, The Children's Memorial Hospital, Chicago, Illinois.

From the Department of Pediatrics, Northwestern University Medical School, and the Division of Endocrinology, The Children's Memorial Hospital, Chicago, Illinois.



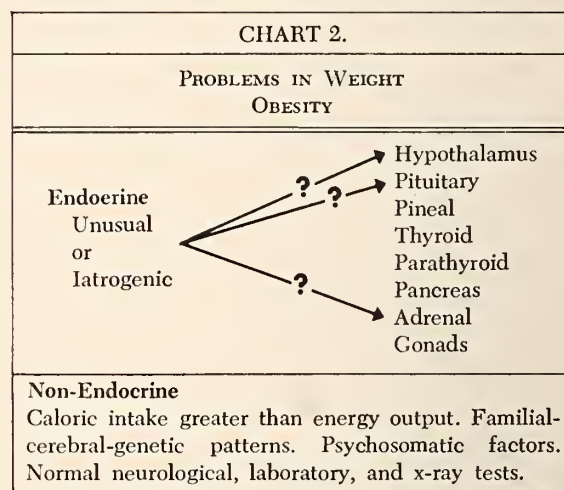
thalamus or the region of the 3rd ventricle, and these are considered to result from imbalance of a so-called "appetstat" mechanism within the hypothalamus. Here neurologic findings are prominent, and there may also be a history of head injury or encephalitis. Laurence-Moon-Biedl syndrome may be an example of such unusual obesity but is often associated with mental deficiency, retinitis pigmentosa and polydactylism.

2. *Pituitary.* Involvement of the pituitary, either primary or associated with hyperadrenocorticism, is very unusual in children—the Cushingoid moon-face obesity and buffalo hump. Within the past few years many such apparent examples have been iatrogenic, resulting from prolonged administration of adrenocorticotropin for various conditions. Extreme obesity in otherwise "normal" children with atypical abdominal striae and pseudo-hypertension (from too narrow blood pressure cuff) have been investigated, and most are *not* secondary to pituitary anomalies. Frohlich's syndrome is still being applied to obese males with relative hypogonadism. The original description by Frohlich in 1901⁴ focused attention to the region of the pituitary in a male with retarded growth and sexual infantilism much like the syndrome later described in two sisters by Lorain and Levi.⁵ Frohlich's patient *later* developed obesity, probably as a result of hypothalamic involvement by an expanding tumor. Hence, Frohlich's syndrome should not be applied to the obese male with normal stature and neurologic findings whose external genitalia appear to be small but in reality are imbedded in excess suprapubic fat.

3. *Thyroid.* Hypothyroidism is often not associated with obesity in children unless caloric intake far exceeds lowered metabolic require-

ments. Many cretins are myxedematous or puffy, but not actually obese. Likewise, many metabolically normal obese children give the impression of hypothyroidism because of sluggishness. Unfortunately many sluggish obese children still continue to receive thyroid because of a "low" basal metabolic rate. It is well to recall that most BMR methods employ surface area standards, and the application of such standards to obese children leads to inaccuracies since obese children have much more surface area than can be accounted for by the surface area standard. Estimations of PBI or BEI given more accurate estimations of the thyroid status of the child and should replace the BMR if possible.

4. *Adrenal.* As mentioned above with the pituitary, adreno-cortical disturbances in children which result in obesity are extremely rare. Again, cortisone administration for various conditions has led to "steroid obesity," and the history will be revealing in such patients.



In general, obesity in children is usually not the result of endocrine disturbance.

B. Non-endocrine Factors^{6a,6b}

The usual obese child is alert, mentally and neurologically normal, and without sex anomalies. The height is normal, even tall, with normal or above normal bone age. In addition to excess caloric intake there is often reduced activity. In a review of the consumption of food it is well to estimate snack foods whose total calories may exceed those consumed at regular meals. Hence, may obese children actually do not overeat at meal times! There may be a familial tendency to obesity, and in our experi-

ence one or both parents were obese in 65-75% of the patients. Some children at an early age exhibit progressive obesity resistant to management with a variety of regimens, and in these there are definite psychosomatic problems which contribute to the persistence and resistance of the obesity. Therefore it is not enough to just weigh the child, prescribe a low calory diet or even one of the anorexigenic drugs and expect to get good results. Such children will overeat despite any regimen, and in fact any restrictive program constitutes an actual threat for food represents more than that necessary to satisfy hunger. Food is "used" as a substitute for needs which are not derived from the environment, whether it is home, social or school. Such children require a different approach if any success is to be achieved, and even with the ideal approach, long term "cure" is limited for the problems of the child and the family are not always possible to solve. The physician should be prepared to devote plenty of time to the child and parents; he needs to show that he is interested in helping the *total* child and not just the problem of excess weight and food intake. It is often best not to bring up the problem of obesity or its management at first, but to attempt with the help of the child and parents to find some motivation, some interest which will provide a substitute for the gratification which these children obtain from food alone.

Obesity then is not a simple disease; it is a symptom of a generalized disturbance in a child who "uses" food as the sole source of gratification. The approach to this patient is the solution of the emotional, social, family and school problems. Often strict diets are actually contraindicated; appetite suppressing drugs are certainly not the solution, and thyroid is definitely useless.

II. Cachexia (Chart 3)

A. Endocrine Factors

1. *Hypothalamus-Pituitary*: Such disturbances are very unusual, may produce extreme cachexia but are often associated with abnormal neurologic findings. Some cases of diabetes insipidus, with or without cranipharyngeal cysts, are associated with loss of weight. Simmonds' cachexia is rare indeed in children.

2. *Thyroid*. Uncontrolled hyperthyroidism can result in cachexia. Here the weight loss despite marked appetite, rapid pulse, moist skin,

CHART 3.	
PROBLEMS IN WEIGHT CACHEXIA	
Endocrine	
Simmonds' Disease	Hypothalamus Pituitary Pineal
Diabetes Insipidus	
Hyperthyroidism	Thyroid Parathyroid Pancreas
Diabetes Mellitus	
Addison's Disease	Adrenal Gonads
Non-Endocrine	
Interference with Intake and Absorption of Food	
Increased Loss of Food or Excretion of Food Products	
Diarrhea and Vomiting	
Gastro-Intestinal Anomalies	
Metabolic Diseases	
Chronic Sepsis	
Neoplasms	

goiter, and exophthalmos will aid in the diagnosis. Most children with hyperthyroidism will have an enlarged thyroid gland.

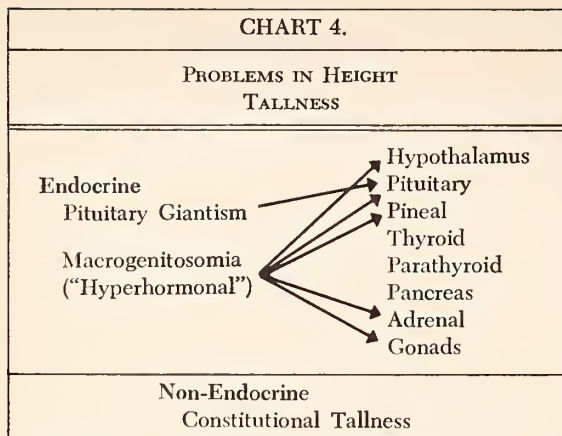
3. *Pancreas*. Uncontrolled diabetes mellitus will result in loss of weight. Thirst, polyuria, possible family history, acetone odor to the breath, and possible skin infections may give the clue to this diagnosis. Often the onset of diabetes occurs after infections when the parents notice loss of weight, polyuria and bed-wetting in a previously trained child.

4. *Adrenal*. In Addison's disease, quite unusual in children, weight loss develops with anorexia, fatigue, constipation, weakness and skin pigmentation particularly over the pressure areas of the body.⁷

B. Non-endocrine Factors

Any condition which interferes with intake of food, with absorption of food, or which increases the output of food products will, if unchecked, result in cachexia. To mention a few of these, we can include diarrhea and vomiting, anomalies of the oropharynx and gastrointestinal tract, tracheo-esophageal fistula, inborn errors of metabolism, fibrocystic disease, celiac syndrome, chronic infections, and sepsis, neoplasms and chronic renal disease. Many of these can be detected with a good history and physical examination.

In general, most cachexia in children is not endocrine, and for that matter, most weight problems in children from the point of view of relative frequency are not the result of endocrine disturbances.



Problems in Height

I. Tallness (Chart 4)

A. Endocrine Factors

1. *Pituitary.* The outstanding endocrine factor is an increase of somatotropic (growth) hormone resulting from a tumor or cyst. History and physical examination with visual fields and fundoscopic are essential in making the diagnosis.

2. *"Hyperhormonal" (Sex).* Tallness associated with elaboration of sex steroids from either hypothalamus, pituitary, pineal, adrenal or gonads. In these patients, sex precocity (iso-sexual or hetero-sexual) is obvious, and the progression of growth is secondary to precocious maturation of epiphyses and increased linear growth of bones.

B. Non-Endocrine Factors

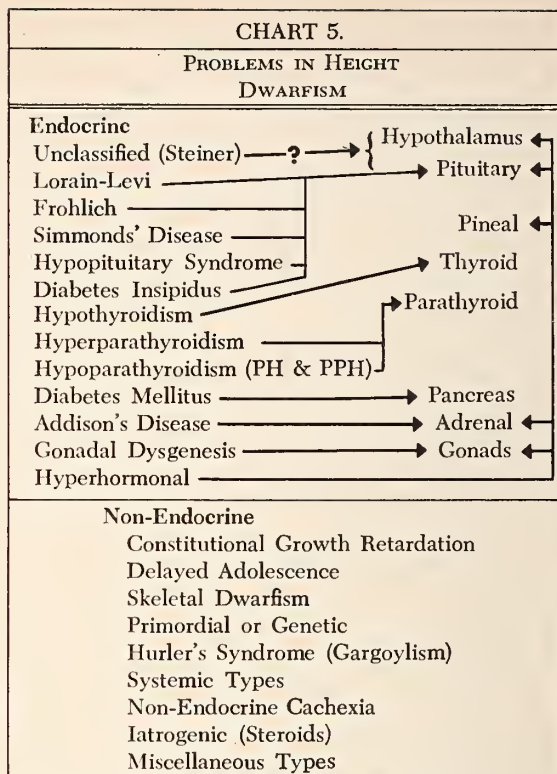
1. *Constitutional Tallness.* This is more likely an atavistic type of tallness, and probably the most common type. Such tallness is seen in basketball centers and in other normal individuals without evidence of a lesion of the pituitary. Other examples are seen in the African "Seven Footers" and in some of the tall Polynesian people of the South Pacific.

In general, most tallness is not endocrine, and again a good history and physical examination are essential in ruling out the more unusual patients with pituitary tumor or sex hormone anomaly.

II. Dwarfism (Chart 5)

A. Endocrine Factors

1. *Hypothalamus-Pituitary.* Some rare types of cerebral dysplasia or hypoplasia of the pituitary and/or hypothalamus have been mentioned. An extremely unusual type has been



reported with dwarfism and chronic hypoglycemia (Steiner's dwarfism). Historically the examples related to pituitary involvement have been described by Froehlich and by Lorain and Levi, and are associated with sexual infantilism. Also, Simmonds' cachexia is associated with dwarfism, and refers to either total or incomplete hypopituitarism.

Usually the diagnosis of hypopituitary dwarfism is an exclusion diagnosis, and should be suspected in a patient with hypoglycemic episodes and marked dwarfism. Such episodes may simulate epileptic seizures. Such children are short, have retarded bone age, and may or may not have abnormal neurologic findings. Often the height age and bone age are close to one another. Hypoglycemia need not be present in the proven case, and one should also elicit the presence of morning headaches or weakness after exertion. Some hypopituitary dwarfs have a characteristic "old age" appearance to the face and texture of the skin; some are fairly normal, alert mentally, bright in school and without stigmata of myxedema. It is well to remember that in hypopituitarism there need not be a total or complete absence of all the trophic hormones of the pituitary; there may be a failure

of one or more of these hormones in addition to failure or insufficiency of the growth hormone.

Diabetes insipidus can also be associated with retarded growth and bone age, either idiopathic or secondary to pathology in the region of the pituitary.

2. *Thyroid*. In the retarded growth of hypothyroidism, history and physical findings often suggest the diagnosis. Cretins are referred to us by the cardiologist who is called to see an infant with congenital heart disease. It is well to "look twice" at the infant with mottled skin, circumoral cyanosis and congenital heart while in the newborn nursery. The quiet, pale, pudgy, myxedematous infant with suspiciously prominent tongue, hoarse cry, and umbilical hernia should suggest the diagnosis early. However, often not all of the characteristic signs are apparent, and it is sometimes difficult to spot these infants in the first weeks of life.

History elicited from the mother should include previous or current thyroid disease and, more important, the intake of anti-thyroid medication during pregnancy. The goitrous cretin should be obvious to the examiner; the size of the goiter varies a great deal and may be large enough to cause respiratory difficulty. With regard to juvenile hypothyroidism, it is well to remember that many syndromes take "time" to develop. Such a patient may begin by doing poorly at school, may develop gradual constipation, anorexia and anemia, and then sluggishness and myxedema. Sometimes, pretibial edema may be a characteristic finding in the juvenile hypothyroid and is to be differentiated from cardiac and renal disease.

3. *Parathyroid*. Hyperparathyroidism secondary to tumor of the parathyroids is extremely unusual in children. The growth retardation is secondary to deformity of the bones and renal disease.

Patients with pseudohypoparathyroidism may exhibit short stature, calcification of soft tissues, shortened metacarpal (absent knuckle) and metatarsal bones, rounded face, and prominent forehead. In pseudo-pseudohypoparathyroidism, similar anatomic features may be found, except that there are normal concentrations of serum calcium and phosphorus. Here family history and physical examination may give important clues. Specific inquiry should be directed with respect to delayed dentition, fractures, cat-

aracts, exostoses, thyroid disease, diabetes mellitus, menstrual abnormalities and tetany. In the physical examination, particular attention should be paid to anomalies of skull, eyes, dentition, nails, feet, hands, subcutaneous calcification, and mental status.

4. *Pancreas*. In some poorly controlled diabetics or in those with inadequate diets, growth retardation has been encountered.

5. *Adrenal*. Addison's disease may be associated with short stature.

6. *Gonads*. Gonadal dysgenesis is associated with and not the cause of retarded growth; the actual cause of the short stature is not known. One should suspect the condition in infancy after careful examination of the newborn infant, e.g. swellings of the hands and/or feet (Bonnieville-Ullrich Syndrome), hair growing down low on the neck with low placed ears, or webbed neck with cardiac murmur (Turner's syndrome). While a buccal smear for sex chromatin is not always reliable in the first week(s) of life, most of these phenotypic females with gonadal dysgenesis have a negative chromatin sex pattern. A larger group of these children have no swellings during infancy and no webbed neck with coarctation of the aorta, and should be suspected on the basis of slow growth, characteristic facies with low placed ears, shield chest with widely spaced nipples, high arched palate, increased carrying angle of elbows, and metacarpal and metatarsal anomalies. Hence, buccal smears for sex chromatin should be done on all short females and certainly in those 15 or 16 year olds who have not yet menstruated.

7. *"Hyperhormonal" (Sex)*. As mentioned above, sex steroids from hypothalamus, pituitary, adrenal and gonads initially stimulate growth to produce tallness. As the process continues, the epiphyses fuse prematurely, growth is arrested, and the patients are shorter than their peers.

B. Non-Endocrine Factors

1. *Constitutional Growth Retardation*. This comprises the largest group of short stature in children! These are children with height below the 10th percentile and often below the 3rd percentile, normal span and body proportions, absence of endocrine stigmata, and normal mental and neurologic examination. They are also known as "slow developers with retarded

adolescence." In Wilkins' classification of 442 patients with stunted growth, close to 50% represented this group together with those showing slow growth and bone age too young for diagnosis.⁹ Other types mentioned were primordial dwarfism (26%), hypothyroidism (dwarfism conspicuous) (12%), syndrome of gonadal aplasia (11%), and hypopituitary or hypothalamic (7%). In our experience, constitutional growth retardation accounted for 70-75% of all the slow growth in children.

Because of the frequency of non-endocrine constitutional growth retardation in children with slow growth, 112 such patients have been studied from the point of view of family and sibling incidence, laboratory evidence of dysfunction of pituitary, adrenal and thyroid glands, as well as psychosomatic disturbances.¹⁰ As far as the family history is concerned, a relationship did not exist between heights of parents, grandparents and siblings. In each of 16 families, 2 or more siblings were similarly affected, and in 26 patients a history of short stature and slow adolescent development was elicited in a total of 38 relatives. There was no effect noted from the type of pregnancy, labor, delivery and length of gestation. Only 12 patients were premature births. In 6 patients there was some suspicion of "intrauterine growth retardation" as evidence by birth weights under 5 pounds with normal length of gestation. The position in the sibling scale as well as the number of children in the family, birth weight, type of feeding, prenatal or postnatal complications or infections did not appear to contribute to the slow growth. The onset of this retardation occurred from 6 to 18 months of age, and in many children the weight also remained between the 3rd and 10th percentile.

Many symptoms were associated with the retarded growth in these children. Anorexia, fatigue, and poor weight gain were most common. Between the ages of 10 and 13 years, a good number of boys complained of being "left out of things" because of poor stamina and size, of being called "runt," or being the smallest in the class, or being ashamed to undress for swimming because of small genitalia.

Laboratory investigations have included x-rays of skull (sella) and epiphyseal maturation (bone age), glucose tolerance, insulin tolerance, water diuresis (Robinson-Power-Kep-

ler), total urinary 17-ketosteroids, total urinary 17-hydroxycorticoids before and after a standard ACTH test, Metapirone test, and protein bound iodine test. We could not detect any abnormality of pituitary, adrenal or thyroid glands in these patients, and the only abnormality was retardation of the bone age. Unless further studies of growth hormone are revealing, we have to conclude that these children are slow developers with respect to height, (weight), epiphyseal maturation and adolescence. It also appears that in many cases this condition is familial and may be genetically determined. Many have been followed beyond adolescence and have developed normally at a later age. Some who have been unusually disturbed about their slow growth have received help from Child Guidance personnel.

2. *Skeletal*. These include specific types of chondrodysplasias and are easily detected by the relative short legs and arms, long trunk and prominent forehead. Morquio's disease falls into this category. Recent studies indicate that there may be an inborn error of metabolism with enzymatic defect responsible for the abnormal cartilaginous development.

3. *Genetic or Primordial*. These are the "Tom Thumb" circus types with normal body proportions and epiphyseal maturation.

4. *Hurler's Syndrome or Gargoylism*. These are characterized by the peculiar gargoyle-like facies, hirsutism, hypertelorism, claw-like fingers, enlarged liver and spleen, and lumbar kyphosis. Not infrequently some of these children are mistaken early for cretins and have been given thyroid without benefit.

6. *Non-Endocrine Cachexia*. Prolonged cachexia will retard growth.

7. *Miscellaneous Types*: Progeria and Cornelia deLange Syndrome.

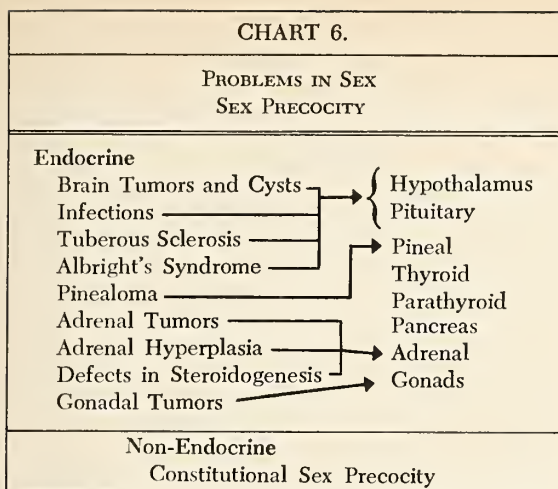
In general, one can say of the child with stunted growth that most are slow developers with retarded bone age, height age, and adolescent development, and especially along with retarded bone age, the PBI is normal and there are no abnormal neurologic findings.

Problems in Sex

I. Sex Precocity (Chart 6)

A. Endocrine Factors

1. *Hypothalamus*. Sex centers have been described within the hypothalamus which, when stimulated to produce sex steroids either in-



dependently or in conjunction with pituitary gonadotrophin, will result in marked sex precocity. There may be associated excessive obesity. History and physical examination should concentrate upon head injuries, tumors, infections, meningitis and/or encephalitis as well as upon abnormal neurologic findings

Tuberous sclerosis, a rare disease in children, can be associated with sex precocity on this basis. Adenoma sebaceum of face and the characteristic glial changes in the fundi are some of the clues in this condition.

The sex precocity in Albright's syndrome is considered by some to be hypothalamic in origin. The triad in the female with sex precocity, skin pigmentation and polyostotic fibrous dysplasia should be kept in mind. History of a "limp" in a patient with sex precocity and skin pigmentation could be a clue to possible bone pathology.

2. *Pituitary*. Isolated pituitary anomalies are very rare in children and elaboration of gonadotropic hormone may be part of the above mentioned hypothalamic syndrome. Primary or secondary changes are considered to occur in hyperadrenocorticism with Cushing's syndrome and sex precocity.

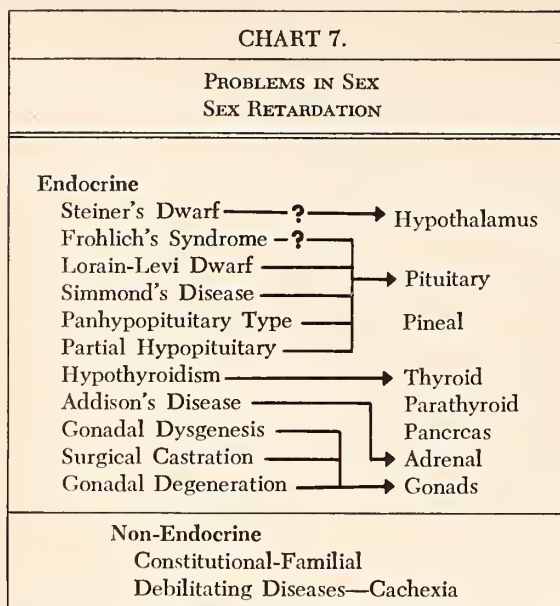
3. *Pineal*. Some pineal tumors, mostly in males, produce sex precocity; the so-called "Hercules" type of macrogenitosomia praecox. There is still considerable discussion whether the disturbance arises from hormone elaboration from the pineal or is secondary to changes in the pituitary. Occasionally such patients with macrogenitosomia praecox have a paralytic squint, and this may be an important clue to pineal involvement since the centers for the

oculomotor nuclei are in close proximity to the pineal gland.

4. *Adrenal*. Generally speaking, the adrenal cortex can be involved in three types of pathologic changes, i.e., carcinoma, adenoma, and hyperplasia. All three types can give rise to a variety of clinical pictures depending upon the relative proportion of hormone excess from the adrenal gland, and the name Cushing's syndrome is applied to this variable clinical syndrome. The clarification of specific pathology underlying Cushing's syndrome involves not only history and physical examination but a variety of x-ray, chemical and/or steroid determinations.¹¹ Briefly, enlarged clitoris, precocious pubic hair, accelerated growth, advanced bone age, mass in the abdomen, acne, and elevated blood pressure represent some helpful clues in a differential diagnosis. A flat plate of the abdomen may reveal calcification above the renal shadows, and the intravenous pyelogram may disclose significant abnormalities. Occasionally pre-sacral air insufflation may differentiate bilateral adrenal enlargement (hyperplasia) from unilateral mass (tumor). Assays of urinary ketogenic steroids and corticoids, response to ACTH stimulation, dexamethasone suppression and serum electrolytes can be employed in a complete investigation. It is well to remember that in a unilateral hormone-producing tumor, the contralateral adrenal gland may be atrophied and non-functioning. Hence, the patient should be supported with steroids before, during and after surgery for removal of the tumor in order to prevent adrenal failure.

Defects in steroidogenesis can manifest either prenatally or postnatally in females as well as in males. We will refer to the literature for details of sites of enzymatic blocks and the chemical aberrations arising therefrom.¹² In addition to virilization, about 30-50% of these infants are also "salt-losers", absolute, partial or potential, and the possibility of salt-losing creates an urgency for early diagnosis and proper management. It is also important to question parents concerning sex anomalies or sudden death in siblings soon after birth, or following a relatively short period of diarrhea or vomiting.

Briefly, in the genesis of female pseudohermaphroditism, there is progressive virilization of the fetus because of a defect in steroidogenesis of the adrenal. When the infant is born,



the "sex is difficult to determine", for the phallus is enlarged, there is complete hypospadias, perineal urethral orifice, all degrees of labio-scrotal fusion, and absent gonads in what may appear to be a rather normal wrinkled scrotal sac. This difficulty in sex determination at birth should alert the physician in the newborn nursery and should not be dismissed entirely as a male with complete hypospadias and abdominal testes. It is vital to make this diagnosis early, for if this infant is an absolute salt loser in addition to a female pseudohermaphrodite, it may not survive without vigorous and prompt therapy. One example of this is the infant who appears listless soon after birth or 1-2 days later, refuses feedings or may vomit and then suddenly expire. While buccal smears for sex chromatin are not entirely reliable soon after birth, they can be repeated, and in addition total 24 hour urine collection for 17-ketosteroids and pregnanetriol. A positive buccal smear (sex chromatin) will suggest a genetic female and/or elevated urinary 17-ketosteroids and pregnanetriol will confirm the diagnosis of female pseudohermaphroditism. There should be available in the newborn nursery equipment for I.V. saline, Solucortef for I.V. use, and DOCA for intramuscular administration should the suspected infant exhibit signs of adrenal failure (salt losing).¹³

Or we may see the infant with female pseudohermaphroditism who appears well for the first two weeks and begins to spit up the for-

mula at home. Despite changes in the formula, the infant continues to vomit intermittently and rapidly develops signs of shock with hypoglycemia and cyanosis.

If the condition is not recognized and cortisone suppression is not instituted, progressive virilization continues with enlargement of the clitoris, precocious pubic hair, facial hair, husky voice, increased musculature, and advanced stature and bone age (hyperhormonal tallness). Eventually, there is premature closure of the epiphyses with resultant short stature (hyperhormonal dwarfism), and many such individuals develop severe psychological disturbances. There are now on record about 8 or 10 patients on cortisone therapy who have delivered normal infants.

In addition to cortisone for the uncomplicated female pseudohermaphrodite, other steroids (mineralocorticoids) are required for the salt-loser, as well as between 1 and 3 grams of salt orally per day. If there is any question about the infant getting oral medication, cortisone can be administered intramuscularly. Also, the mineralocorticoid can be implanted subcutaneously as DCA pellets (75 or 125 mg.) and their effect will continue between 6 and 9 months. Otherwise, Florinef (9 alpha fluoro-hydrocortisone) can be given orally, usually in dosage of 0.1 mg daily. In some children with partial salt-losing, just cortisone and extra salt may suffice. In the follow-up of the adequacy of therapy in these children, not only are we interested in estimations of satisfactory urinary 17-ketosteroid suppression, but also pertinent physical findings, e.g., height, size of genitalia, as well as epiphyseal maturation. In some salt losers, serum electrolytes may be helpful.

The male infant with adrenogenital syndrome and salt losing is much more difficult to suspect early in life, for the genitalia are normal. Again, the family history may give important clues if a newborn died suddenly or developed a shock-like syndrome following a mild infection with diarrhea or vomiting. There are several clinical syndromes which should alert the physician at least to the possibility of adrenogenital syndrome with salt-losing in a male infant. Untreated, these infants develop a shock-like syndrome, gradually or rapidly, with hyponatremia, hypochloremia, hyperkalemia, low CO₂ and hypoglycemia. Intravenous saline

and glucose, cortisone and DCA are life saving measures. A male infant with family history unknown may appear lusty at birth but begins to vomit 1 or 2 days later, appears listless with weakened cry and seems unusually dry for the amount of fluid lost in a short time. Or such an infant may not get into trouble until after going home from the nursery usually in the first two weeks of life. The rapidity of change from a well to a very sick child as well as the lack of correlation of the dehydration with the minimal vomiting or diarrhea in the absence of overt infection are important clues. Another group of male infants (who in retrospect are partial or potential salt-losers) may do well for several weeks and then develop mild infection with diarrhea and vomiting, or there may be no obvious infection or fever associated with the diarrhea or vomiting. Here again the extent of dehydration and the sickness of the child do not fit the history of rather benign loss of fluid, and one is inclined to doubt the history of such a patient. Even at this time, the external genitalia may not be remarkable, and hence no obvious visible clue to the underlying disturbance.

Such an infant, treated routinely with intravenous saline or mixtures of glucose and saline, appears to rehydrate rapidly and recover. However, when intravenous fluids are discontinued and the infant is placed on dilute formula, the symptoms of dehydration recur rapidly, and the physician is ready to doubt whether the resident carried out his orders. Replacement with I.V. fluids again corrects the vomiting, diarrhea and dehydration, only to recur again when oral fluids are started. Such a child may exhibit no unusual alterations of serum electrolytes, and there is also no evidence of chronic pyelonephritis or congenital polycystic kidneys. Stools are negative for pathogens and urine colony counts and culture are not abnormal.

Another group of children may enter the hospital and exhibit a similar syndrome of dehydration unrelated to the history, similar response to intravenous saline and recurrence with oral feedings, but will exhibit hyponatremia, hypochloremia and hyperkalemia. It is also notable that this infant requires intravenously up to 3 or 4 grams of salt daily in order to maintain adequate clinical hydration and electrolyte balance. In view of the possi-

bility of selective loss of salt and retention of potassium by abnormal tubules in chronic pyelonephritis, repeated urinalysis, cultures and colony counts are made but show no abnormality. Also stool cultures are negative for pathogens. Again, these infants dehydrate rapidly when placed on oral fluids without adequate salt.

Still another group of male infants may be hospitalized repeatedly for vomiting, diarrhea and dehydration with normal electrolyte balance until someone "looks twice" at the external genitalia and is suspicious of some enlargement. Estimation of urinary 17-ketosteroids reveals elevated levels and at this time there may be hyperkalemia and hyponatremia.

Following initial management with adequate intravenous saline and glucose supplemented with Solu-Cortef and DCA I.M. or DCA pellets, these infants generally require from 2.5 to 5 mg. prednisone daily and 0.1 mg. Florinef. Some infants get over their absolute salt losing tendency and may only require cortisone and between 3 and 4 grams of salt daily, which can be given in cereals or vegetables. With such infants it is well to remind the parents that when infection ensues, additional salt and even additional cortisone and Florinef according to the physician's judgment. In other words, there should be constant rapport between the parents and the physician, not only for routine checks in possible "breakthrough", but also in cases of infections and stressful accidents.

5. *Gonads.* In females, theca cell, granulosa cell, and luteomas are some of the tumors which produce isosexual precocity. Arrhenoblastoma result in virilization. Careful palpation of the abdomen and recto-abdominal examination, even under anesthesia, are prerequisites for adequate examination of the female with sex precocity. In our experience, abdominal pneumoperitoneum has been most helpful in detecting unilateral tumors and also unilateral functioning follicular cysts.⁴ Sex precocity with unilateral follicular cysts, not neoplastic, have been described and the removal of the unilateral cyst has resulted in cessation of sex precocity. In males, interstitial cell tumor of the testis causes iso-sexual precocity. Careful palpation of scrotal testes with possible biopsy may be necessary. Abdominal testes should be under suspicion.

B. Non-Endocrine Factors

Students are surprised to learn that most sex precocity (80-90% in female and 40-60% in male) is not endocrine, and is said to be the result of premature gonadotropic stimulation acting upon responsive target organs. It is likewise postulated that such target organs may also be sensitive to normal amounts of gonadotropic hormones. These are classified as constitutional, familial or idiopathic types of sex precocity. One should try to elicit a family history of similar precocity in sibs or relatives in order to establish the fact that these may be on an hereditary basis. It is well to keep such children under careful observation for many years, since involvement of an endocrine gland may become manifest at a later date. Several conditions should be considered in the differential diagnosis of constitutional sex precocity. Enlargement of the breasts alone at any age may occur in the female child ("precocious thelarche") not associated with any other manifestation of sex precocity, that is, no sexual hair, no changes in vaginal epithelium, menses or alteration of gonadotropic hormone. There is also the child with premature development of pubic hair without any other changes as described above, the so-called "precocious pubarche". One should be on the watch for changes in the clitoris to differentiate the virilizing effect of adrenocortical disturbance. Another possibility is the child with bilateral galactoceles. Such a child has been recently observed, an 8 month old male, with cystic breasts containing milk-like fluid and in whom assays for steroids and estrogens were normal. The cysts were removed surgically and have not recurred. Also there are unusual children with hypothyroidism who develop sexual changes, and it is notable that when these children are treated with thyroid, the sexual changes disappear. There is also the rare occurrence of sex precocity with severe liver disturbances.

In all sex precocity one should elicit a careful family history to rule out iatrogenic etiology, i.e., whether there are hormone drugs at home and what work the mother or father are engaged in as to possible home contamination with steroid products. Recently we observed a 3 year old female with enlarged breasts where both parents were employed in a hormone

packaging plant. They were not accustomed to changing their work clothing at home, and after a period of months there was enlargement of the child's breasts. When the parents were advised to remove all contaminated clothing from the child, the breasts receded.

True sex precocity, isosexual precocity, also called constitutional, idiopathic or familial occurs in about 80-90% of females and about 40-60% of males. These children show all the signs of precocious secondary sex development; in the female, enlarged breasts, pubic hair and menses; in the male; pigmentation of areolae and scrotum, pubic hair and enlarged external genitalia. It is important to remember from the point of view of the differential diagnosis from pseudo-sex precocity of adrenogenital disturbance, that along with the enlargement of the penis, the testes are similarly enlarged as in normal adolescence. In the adrenogenital syndrome, the testes are relatively small despite other evidence of sex precocity. As a result of premature elaboration of sex hormones and macrosomia children with true sex precocity have advanced bone age, grow tall, become muscular but eventually end up being rather short because of premature closure of the epiphyses. Aside from the clinical manifestations of unusual growth and development, psychosexual or psychosomatic disturbances may arise, and one has to exercise good judgment to guide these children and their parents through a very trying period until they eventually catch up to the age when sexual changes are acceptable. Pregnancies are not infrequent in these children, lactation generally does not occur, and premature menopause does not occur.

Specific management or therapy for these children is not satisfactory for *all* manifestations of their sexual precocity. We have used medroxy-progesterone (Depo-Provera) intramuscularly in doses of 100-200 mg. every 10 to 12 days in an attempt to suppress gonadotropic hormone and ameliorate the sexual changes. While we have obtained remission or regression with respect to breasts, pubic hair and menstrual flow, we have not been able to retard the advancing bone age or the progression in height.

II. Sex Retardation (Chart 7)

A. Endocrine Factors

1. *Hypothalamus-Pituitary*. Various types of

disturbances of the hypothalamic-pituitary axis have been mentioned above. A deficiency of gonadotropic hormone will result in sexual infantilism. Steiner's dwarfism, Frohlich's, Lorain-Levi and Simmonds' syndromes are all characterized by failure of sex development. It is well to remember that most endocrine syndromes are not "all-or-none", and that partial types of hypopituitarism may occur, for example, with sex retardation alone.

2. *Thyroid*. Hypothyroidism retards sex development.

3. *Adrenal*. Addison's disease can be associated with slow sex development when sex steroids are involved.

4. *Gonads*. This has been discussed under Retarded Growth. Surgical castration, prepuberal, either for disease or social reasons as in eunuchs will, of course, result in failure of sex changes. Watch out for Klinefelter's syndrome in the male with small soft testes or in males after age 16 with female body habitus and small penis and soft testes. Buccal smears in such males are often positive, and one should resort to testicular biopsy and estimate the gonadotropic hormone in the urine.

B. Non-Endocrine Factors

This has been discussed above under constitutional growth development with retarded adolescence. However, any female over age 16 should be viewed with suspicion and the cause

for the amenorrhea and retarded sex development should be investigated. Remember to do a buccal smear for sex chromatin in the short female with minimal sex development. It is not known what percentage of children comprise the group of so-called constitutional sex retardation. Debilitating diseases or non-endocrine cachexia can retard development. Beware of the condition which results from failure of end-organ response (breasts or penis) for hormone treatment of such patients is disappointing and sometimes harmful.

Summary

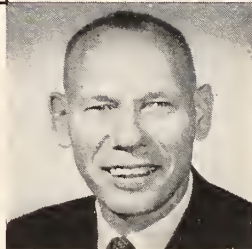
An attempt has been made to present schematically clinical aspects of endocrine disorders in children as variations in weight, height, and sex. Specific clinical history and physical findings have been stressed dogmatically as they pertained to hallmarks or leads in making a diagnosis. Simple charts have been employed in each clinical category to aid the practitioner not only in pinpointing possible etiology of the presenting problem, but also in estimating the relative frequency of endocrine versus non-endocrine aspects of the condition. No attempt has been made to delve into the voluminous literature, to discuss the pitfalls of laboratory analyses, or to review specific problems of therapy.

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MEDICINE IN THE OUT OF DOORS



Julius M. Kowalski, M.D.,
Princeton

TWO ZOONOSES

"Lord! how sad a sight it is to see the streets empty of people. . . . Jealous of every door that one sees shut up, lest it should be the plague."

Samuel Pepys—*Diary*, August 1665.

ANIMAL DISEASES IN MAN today are not the scourge of the Black Death of plague known in the mid 17th and 14th centuries which decimated one-fourth of Europe. Nonetheless, 150 diseases in man result from animal contact; but only 63 are found in the United States. Many of these are occupational hazards arising from frequent and intimate association with diseased animals or carcasses, and persons so engaged are alert to these risks. The occasional outdoorsman, however, is often unmindful of zoonoses which cause lingering, undiagnosed illness. Except in predominantly rural areas, they occur infrequently, perplexing the physician and debilitating the patient.

Tularemia

The hunter dressing out a day's take of rabbit or squirrel, a trapper skinning his muskrats, and even the housewife preparing a barnyard or wild fowl for the oven, expose themselves to this disease. The handling of a diseased carcass is the usual manner by which humans become afflicted with tularemia.

Being a septicemic disease, the etiologic bacteria *Pasturella tularensis* is found in all tissues and body fluids, but can be identified most readily in the liver. In a healthy animal the liver surface is always smooth and glistening, whereas in a tularemic one, protruberances—match-head size or smaller—are seen. On slicing this organ in $\frac{1}{8}$ th or $\frac{1}{4}$ th inch sections, yellowish-white nodules 2-3 mm. in diameter and many smaller ones, barely discernible without the aid of magnification, will be found. These are carbuncles—accumulations of necrotic tissue and pus which teem with bacteria—and result in the protrusions on the liver surface. Any animal with such findings should be discarded, preferably by burning or burying. Physicians or veterinarians can help confirm this diagnosis in animals.

If one has handled a carcass, hide or entrails and then is dismayed to discover that the animal might be diseased, his only recourse is thorough and repeated hand washing. Ridding one's skin of all blood and animal fluids, particularly at the edges and underneath the finger nails and from any abrasions or minor lacerations, is imperative.

Any splashing which strike on or near the eyes while cleaning a carcass should be rinsed repeatedly with water. The cardinal first aid rule for any noxious substance in the eye is immediate and copious dilution with water—all the

more so with suspected tularemia, since the organism possesses the ability to make entry through intact mucous membrane and even through unbroken skin.

A sound preventive measure in dressing all wild animals is the wearing of rubber gloves, thus halting or minimizing the transmission of obvious or hidden diseases. Disposable plastic gloves as used for diagnostic procedures in clinics and hospitals serve this purpose.

The average individual is likely to misinterpret the onset of tularemia as influenza since the prodromal symptoms of both are similar. The illness begins suddenly with chills, fever, severe headaches, generalized aches and fatigue as predominant complaints. The temperature remains elevated (104 degrees or higher). The incubation period with these findings varies from one to ten days.

Concurrently there invariably develops an inflamed, painful area surrounding a previous laceration, abrasion or puncture on the hands. The eye may be irritated if a contaminated finger stroked it while dressing a diseased carcass, or from splashing. Characteristically, the inflamed area does not heal as the usual small wound should, but progresses to a punched-out ulcer. This then was the portal of entry for *P. tularensis*. Painful, enlarged lymph glands in the affected extremity develop in one or two days after the dramatic onset of illness.

Fortunately, tularemia is a relatively rare disease. The reported cases for the United States in 1963 numbered 327 and in 1964 there were 320. In Illinois the figures were 24 cases in 1963 and 19 in 1964.¹ Its diagnosis is confirmed by established laboratory methods and it is treated with antibiotics.

Rabies

Rabies is an infectious disease involving the central nervous system of all warm-blooded animals and, to a lesser extent, birds. The virus is often present in the saliva of the diseased and is transmitted in bites or by licks on skin broken by seemingly insignificant abrasions or lacerations. It is not spread by arthropods or insects.

All unprovoked attacks on persons by any animal must be regarded with concern though many thousands of such assaults occur yearly, most of them by animals of known owners. The

animal must be kept under surveillance since the course of treatment in humans depends on whether or not rabies or suggestive evidence of the disease develops in the biting animal. It is impossible for the average individual to identify a wild animal, for example, a squirrel from others of its species in a park or camping area if it should inflict a bite. Further, attempts to live-trap a suspect animal for study invariably end in failures. The folly of hand feeding squirrels, chipmunks or other wild or somewhat tame animals is apparent. Offending dogs and cats are more easily identified by size, distinctive coloring and species.

Since there are no proven cases of recovery in *untreated* humans, it is imperative to have the animal in custody of a licensed veterinarian or a local law enforcing agency for an observation period of ten days.

In Illinois and most states, dog and other animal bites fall into the category of Reportable Diseases and Conditions and are to be reported to the state or local health department. Notification is to be given in every instance in which a person has been bitten by a dog or other animal or in which there is a reason to believe that the wet saliva of a suspect animal has come in direct contact with fresh, open or raw pre-existent abrasions or lacerations.²

The animal is considered potentially infectious: (1) if it is clinically rabid, even though the post-mortem brain examination fails to reveal Negri bodies, (2) if the brain of the animal shows Negri bodies, even though the clinical behavior before death was not suggestive of rabies, (3) if the animal disappears after assaulting a person or cannot be definitely identified, (4) if the animal bites without provocation and is immediately killed even though the laboratory findings are negative.

If the animal is accidentally killed, its head should be detached without mutilation and forwarded to a state laboratory where examinations for rabies can be made. Postal laws do not permit the shipment of animal heads by mail. Such shipment must conform to regulations of the Railway Express Agency and the Illinois Department of Public Health. The head of an animal must be placed in a metal container which will not permit leakage of fluids. Such container shall then be placed within a protective container of wood or metal and packed in

ice or cans of frozen refrigerant. Thorough refrigeration is most important, especially in warm weather, since brain tissue decomposes rapidly making laboratory examination for pathognomonic Negri bodies difficult or impossible. All such packages must be labelled: "CAUTION—This package contains the head of a dog (or other animal) suspected of rabies."

Laboratories of the Illinois Department of Public Health performing rabies examination are located in Chicago, Carbondale, East St. Louis and Springfield. Other laboratories rendering this service are the Chicago Board of Health laboratory in Chicago, the Illinois Department of Agriculture diagnostic facilities in Centralis, Peoria, and the College of Veterinary Medicine, University of Illinois, Urbana.

With such widespread facilities available, and the ease of modern transportation, whenever human welfare is in jeopardy, delivery of a properly packaged container can be made by auto, especially if shipment by Railway Express would arrive at its destination on a week-end or holiday.

The Illinois Department of Public Health stresses the necessity of treating animal inflicted wounds as soon after occurrence as possible in order to prevent spread of the virus. Thorough swabbing with 1% Zephiran Chloride solution, or irrigating with 20% solution of green soap is recommended. If Zephiran Chloride is used, each wound should be swabbed with several impregnated swabs in succession. If soap is used, copious irrigations should force the solution into the wounds from a syringe through a blunt, large gauge needle.

Suturing is not generally recommended where the risk of rabies is likely, since this enhances

the development of the disease. Prophylactic antibiotic and tetanus therapy is desirable in all serious bite cases, but routine antibiotic prophylaxis for trivial or minor animal bites is not recommended. Every bite case should be reported, individually evaluated, and treated.³

The all important post-exposure treatment is determined by several criteria, each having additional requisites for specific cases. A detailed therapy outline is prepared and revised periodically by the Expert Committee on Rabies of the World Health Organization. The complete table is obtainable from any health department office. Vaccination should be started immediately in any patient if the following conditions exist, regardless of laboratory results:

(1) if bite is severe, multiple, or on the face, neck or head

(2) if assaulting animal escapes or is killed

(3) if it is a wild animal (skunk, fox, squirrel, bat, etc.)

A number of rabies vaccines are available as is hyperimmune serum. Prophylactic treatment supplies are furnished free of charge by the Illinois Department of Public Health through regional and local health departments.

In Illinois in the past few years, more than 3,000 animal heads have been examined annually. The number of confirmed diagnoses is about 1 in 25. Approximately 750 Illinoisians receive antirabies treatment yearly.

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The View Box

LEON LOVE, M.D.

Director, Diagnostic Radiology
Cook County Hospital

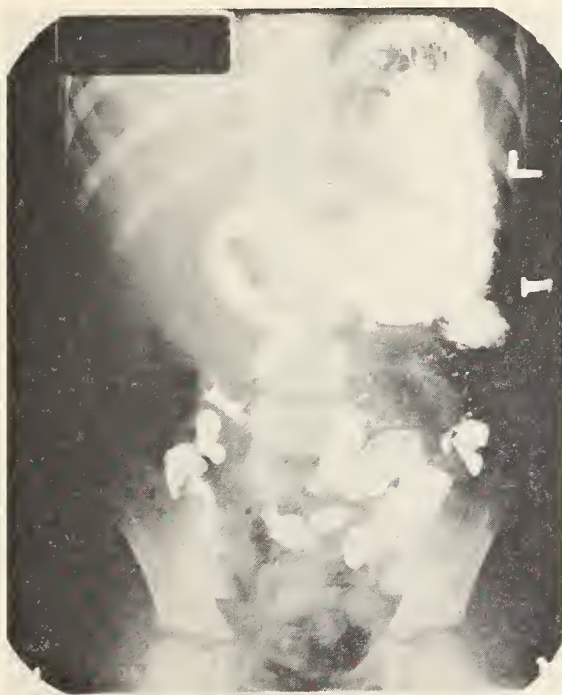


Figure 1.

This 8-year-old Negro female presented at the Cook County Hospital with vomiting of 3 days' duration with no prior illness.

Physical examination revealed tenderness on palpation and generalized rigidity over the abdomen, but no definite localizing signs. The vomiting stopped after 2 days of observation, and gastrointestinal X-rays were done.

Lab. results: 3.2 RBS's, 12,000 WBC's and 37% Hgb.

What is your diagnosis?

- 1) Lymphosarcoma
- 2) Intramural intestinal hemorrhage
- 3) Mesenteric thrombosis
- 4) Multiple abdominal abscess

(Answer on next page)

The View Box

—diagnosis and discussion (Continued from preceding page)

Diagnosis: Intramural intestinal hemorrhage



Figure 2.

The radiographic appearance of the small and large bowel is typical of this entity.

In the small bowel (see Figures 1 & 2) there is uniform, regular thickening of the mucosal folds which have sharply delineated margins and a parallel arrangement so-called "stack of coins" appearance. The narrowing of the second part of the duodenum is a result of hemorrhage and thickening in the wall. (Fig. 2.).

In the colon two types of changes occur: 1) similar to the small bowel (Fig. 3) with thickening and spreading of the mucosal fold, and 2) pseudotumor effect from hemorrhagic mass. The folds show no evidence of ulceration.

Further questioning of the child indicated that she had been kicked in the abdomen about one week previously by an older boy. Her condition improved, and one month after admission her upper GI series and colon examination were normal.

This condition may also occur following extensive anticoagulant therapy.



Figure 3.

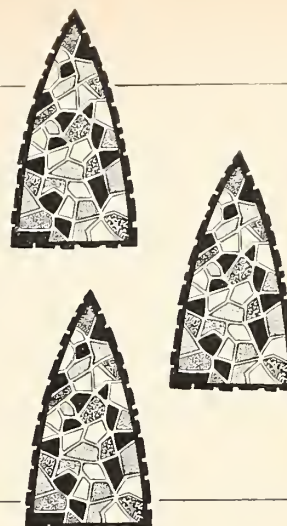
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SPECIAL MEDICINE-RELIGION COMMITTEE REPORT

ARE YOU MEETING YOUR PATIENTS' TOTAL NEEDS?

Joseph R. Mallory, M.D./mattoon



Everyday the physician faces spiritual problems that vitally affect his patients' well-being. How can he learn to cope with these problems more effectively? "By a sharing of experience" answers Dr. Mallory, as he describes a unique, new "PG Course" in which YOU are both student and teacher.

MAN IS AN INSEPARABLE union of body and spirit.

The truth of this statement is demonstrated vividly—and often dramatically—in the practice of medicine. Almost daily the physician witnesses an example of the restorative and healing powers of faith. In addition, he is continually confronted with such practical spiritual decisions as:

1. How do I console the bereaved family of a patient who has died?
2. Should I offer spiritual guidance to a gravely ill patient when no clergyman is available?
3. Am I permitted to baptize a newborn infant in immanent danger of death?
4. Am I permitted to treat a patient whose religious beliefs forbid transfusions, injections or surgical treatment?

Aside from these weighty problems are less serious but equally sensitive questions: How frequently and for how long should a clergyman be permitted to visit a seriously ill patient? Can religious dietary laws be broken for good medical reasons? What protocol should

be exercised when examining or treating members of the clergy?

Until recently, the physician had nothing to guide him in resolving these problems save his own judgment and instincts. For the most part his social maturity and good common sense have stood him in good stead when these problems arose. Occasionally, however, well-intended but misplaced conduct by physicians in spiritual matters has ended tragically—both for him and the patient.

Who can forget the violent newspaper attacks on the physician whose refusal to give a pregnant, unmarried teenager spiritual comfort resulted in her despondence and attempted suicide? Who doesn't cringe at news of a recent law suit filed against a physician because he would not permit a terminally ill patient to see a clergyman?

Rare and extreme as these illustrations are, they point up an undeniable fact: the patient's *total* welfare frequently depends on the physician's ability to cope with the SPIRITUAL—as well as the PHYSICAL—aspects of illness.

To train physicians to perform this task more efficiently, the American Medical Association formed a Department of Medicine and Religion four years ago. Through this department the

Chairman, Committee on Medicine and Religion,
Illinois State Medical Society.

Illinois State Medical Society Committee on Medicine and Religion was instituted two years ago.

From the outset it became apparent to your committee that the best way for a physician to obtain knowledge on the spiritual problems of medical practice is to share his experiences with colleagues and with members of the clergy. Out of this realization was born the highly effective "Clinical-Clergical Case Conferences" in which physicians actually met on the county level to discuss the total spiritual dimensions of patient care.

Based on the success of these conferences your Society's Committee on Medicine and Religion is instituting a new, continuing series in the *Illinois Medical Journal*.

This series is not only new, but unique. Called "Clinical-Clergical Case Report," it permits YOU, the individual physician, to share your personal experience on medicine and religion with your colleagues in Illinois. The articles can cover virtually any aspect of medical-spiritual relationships in the total treatment of the patient. It may be serious, humorous, or in between—as long as it treats some problem from which you feel your colleagues will benefit. Due to space limitations for this new series we prefer that each article be confined to a maximum of 1,000 words.

In order to begin this series as soon as possible we urge you to submit your particular experience or experiences in article form now. Please send them to:

Committee on Medicine and Religion
c/o Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois 60601

Through this sharing of experience—in which you are both teacher and student—you will become enrolled in a unique new "postgraduate

course" which will help you and your colleagues to meet the total needs of your patients more effectively.



SURVEILLANCE

Unless physicians continue to assure the public and meet their own demands for upgrading medical services, governmental departments will take the lead in directing them.

SURVEILLANCE, according to *Webster's New Collegiate Dictionary*, means "close supervision, close watch or constant guard." The word as used in this discussion implies supervision in part, but also evaluation, adjudication, and education or orientation. The meritorious attainments through surveillance of professional care are acknowledged. For current status on

surveillance, unrestrained credit must go in part to the Joint Commission on Accreditation of Hospitals.

Purpose

The purpose of surveillance is not the regulation or enforcement of rules developed by voluntary agencies from without and committees from within but for documenting and guaranteeing the quality of the medical services. The purpose serves additionally for stimulating education, for encouraging scientific leadership and for fostering team work of three principals in the health team: the medical staff, the hospital administration, and the governing board.

With the purpose of surveillance identified, each unit within the institution becomes of secondary importance to the whole team.

Method of Self-Policing

The fact that a quickened cadence in the evolution of medical sciences has occurred is reason enough to desire re-evaluation or documentation of excellence in the quality of care. This evolution involves advancements in diagnosis, therapy, rehabilitation, earlier detection of illness and prevention of accidents and diseases.

Methods of self-judging may be done by the staff as a whole. But even for a small staff this may be cumbersome. Ordinarily one or more committees is the usual pattern of operation. In larger hospital staffs this work is distributed to an increased number of committees.

SURVEILLANCE OF PROFESSIONAL CARE

H. Close Hesseltine, M.D./chicago

Department of Obstetrics and Gynecology of the University of Chicago and the Chicago Lying-in Hospital.

Presented before the American Hospital Association on Panel, "On Surveillance," August 24, 1964.

Three committees for evaluation stand out boldly. These may be known as 1) Medical Records, 2) Tissue, and 3) Utilization. For the future one must rely upon anticipation of new zones in need of surveillance. These may include: 1) Accommodations; 2) Patient Placement and Movement; 3) Visitor Control; 4) Traffic Management; 5) Environment and Pollution Matters; 6) Construction; and 7) Quality of Medical, Pediatric, Laboratories and Ancillary Services. The details of these will be given later.

Current Committees

Medical Records Committee: The purpose and function of the medical record is known. Yet aspects of evaluation need stressing. It should not be judged by size, volume, or length of notes and number of tests. The approved record should present a clear and precise chronology of the patient's health condition. Not only is it valuable for the patient's care, but it may be inestimably important in the event of medico-legal action. A good summary or review of one paragraph may be more informative than a lengthy, ill-designed and ill thought out presentation.

Tissues Committee: This committee has been charged with evaluation of the procedures in surgery. Today the ethics and competence of surgeons have largely replaced the need for this committee.

Utilization Committee: Criticisms of utilization of hospital beds have occurred. The accusations have been directed both to prolonged and unnecessary use and others complain of insufficient use or under utilization. Let us realize that medicine is not as exact a science as mathematics. Just as one individual may recover unpredictably from each new cold, different individuals do not recover from illnesses at the same rate. The convalescence following an appendectomy or an obstetric delivery will vary from patient to patient. Therefore an arbitrarily fixed number of days for determining proper utilization is fallacious. It is not our purpose to be in a contest to obtain the shortest possible Hospital stay. Our goal should be the most efficient utilization of hospital beds in the best interests of the patients. The Utiliza-

tion Committee is concerned with all aspects of utilization: insufficient and under, over and unnecessary, and adequate and proper. Substantial evidence indicates that over and unnecessary utilization is insignificantly low and rarely deliberate. Deliberateness when it occurs more often is chargeable to the patient who refuses to be discharged. Various means may be needed to induce these few individuals to depart from the Hospital. This situation is not the fault of the physician, the administrative staff or the governing board. It is embarrassing to the Medical and Nursing Staffs and it is frustrating to the administrative officers.

Most people react naturally against hospitalization. These and other safeguards rather effectively preclude over and unnecessary utilization.

New Committees

The anticipation of problems in the evolving health services calls for consideration of anticipation of changes in surveillance. Thus functions of committees will change and new ones may be needed.

A number of items concern all of us as well as the patient. Some of these are listed below.

1) *Accommodation:* The number of occupants in any given area is related to allowable space, common decency and Health Department regulations. A convalescing person is unhappy when a seriously ill patient is placed in the room. The public is turning away from ward accommodation. Even though smaller units cost more to build and to operate the recognition of patients' needs and reactions and environmental factors inherent in the care of the sick today dictate future plans.

2A) *Patient Placement:* The proper placement of patients is a medical and an administrative responsibility. Patients with common conditions are better served ordinarily in areas together. For instance, ophthalmological surgical cases and all non-infectious cases should be kept apart from infectious environments. On the other hand nursing and other services support better care when the same types of cases are housed together. For instance, one may mention divisions for the diabetic, cardiac, or post operative patients.

2B) *Patient Traffic:* The traffic of out-patients into areas of in-patients and of the hospitalized

patients among themselves increases the risk of exposure to communicable diseases and other undesirable items.

3) *Environment and Pollution:* Environmental and pollutional factors face us daily. The problems of the "cloud menace" or germ disseminations, air pollution, air currents with heating and cooling features, isotopes and radiation, hazardous substances and new drugs are too extensive to explore in this discussion. Even so, potential and actual problems and preventative measures require the effective policing by both the medical and administrative staffs.

4) *Visitor Control:* It is an established fact that visitors may be more harmful than beneficial. The number of and conditions for visitors must be decided by those concerned with the care of the patient. Visitors, by all means must be kept out of birthrooms, operating rooms, and intensive care centers. The non-professional individual not only exposes himself to risks but may contribute detrimentally to the patient. Moreover, there is no established medical or psychological value for lay people in these areas.

5) *Construction:* Architectural designs of hospitals are undergoing changes to meet the needs of today. With the improvements in diagnosis, therapies and procedures one must expect, yes, is forced to yield to, newness. It is likely that the future will witness plans and designs strangely different than the present. Plans for a new hospital or its alteration should be carefully and deliberately studied. Hastily planned and constructed facilities, especially for the presumed sake of economy, not uncommonly must have expensive alterations in the immediate future. Is this professional surveillance? Why not?—the place is intended for medical care.

An illustration of benefit by detailed and professional planning is found in the new, magnificent, and efficient operating unit at Michael Reese Hospital in Chicago. A committee composed of board members, administrative corps, engineers, and the surgical staff of physicians and nurses spent some two years in travel, inspection, and research on improvements and efficiency. The cost of the studies was substantial, most likely. But it is reliably reported that this unit is by far the best equipped, superiorly

efficient, and thoroughly praised. The purpose of construction was amply fulfilled, was it not?

Architects of hospitals possess considerable knowledge but they are not authorities in sanitation, public health, microbiology and cannot be expected to be knowledgeable in the latest requirements for equipment and construction in diagnoses, therapies, and services. Therefore the architectural firm can be aided by special consultants and by a dedicated committee. If hospitals are to continue in their proper role, they must continually upgrade themselves.

6) *Service Traffic:* This traffic problem relates to the provisions of foods and supplies for patients, the collection of wastes, soiled and contaminated materials and their removal and disposal. Surely these points call for equally serious supervision. Proper traffic movement will increase safety and decrease the risk of contaminations.

Improvement of Surveillance

The question on the merit of an outside audit for surveillance keeps repeating. Experience has shown that institutions with larger and soundly organized staffs do well by self policing. Occasionally an independent "Medical" audit might have merit. A satisfactorily organized and properly administered hospital should have no apprehensions about an outside audit. The investigation and survey conducted on a voluntary basis by the Joint Commission on Accreditation of Hospitals provides an audit, gives directions and offers leadership.

All hospitals should be teaching centers. This is part of surveillance. Every birthroom and every operating room should be so planned with an observation area that can be entered from the corridor for the use by nurses or medical staff. This reduces to a minimum the individuals in the work zone yet provides excellently for medical and nursing surveillance and education.

The senior staff men can observe the performance of the younger members. This evaluation of the clinical abilities is germane to surveillance. Younger staff people may profit by watching the senior members work. The professional and moral responsibilities of surgery and delivery call for top performance at all times, yet the presence of scientific observers encourages the operator to aspire for perfection. This observa-

tion by one's peers assures the public that surgery is not done "behind closed doors."

Staff Appointments

Another matter related to surveillance is the responsibility of the governing board for staff appointments. This governing board has the legal and moral responsibility for the appointment of a competent medical staff. Yet the Board members do not have the medical and scientific knowledge to evaluate physicians. Moreover, this board must guard itself against the improperly ambitious and be immune to those motivated by self-aggrandizement. In the instance of developing a new staff, the Governing Board may wisely seek advice from senior or recognized professional men at other institutions in the community whose impartiality, leadership, and professional competence are beyond doubt. After a medical staff is appointed and functioning, especially in larger hospitals, enough men of stature are available from whom the board may obtain advice. The Board of a smaller hospital may elect periodically and privately to obtain outside opinions about the members of its staff as well as an audit.

Appointments and reappointments to the staff are usually annual. If the chief of staff and the departmental or division heads are to advise the board, then should not their appointment be made in advance of the general staff? It is assumed that the chief of service and departmental head would be richly endowed in professional ability, integrity, fairness, and tolerance.

Insurance

The Governing Board may see fit to require the medical staff members to carry adequate and proper medico-legal liability insurance. The hospital has a responsibility to provide appropriate coverage for those staff members serving the institution and working on staff committees. The medical staff should also consider the desirability of requiring each of its members to carry reasonable amounts of professional liability insurance.

Responsibilities and Surveillance

The medical staff has the medical responsi-

bility, as well as the moral and ethical obligations to provide the best possible care. The administrative staff has the responsibilities to conduct and administer the institution in concert with medical direction and in compliance with health regulations. To expedite the deliverance of quality medical care there should be a reliable and direct means of communication between: a) the governing board and the medical staff, b) the governing board and the administrative staff, and c) the medical staff and the administrative staff.

It is proposed that the chief of staff and the heads of divisions meet periodically with the governing board. The medical staff members need not have a vote but should have a voice in matters pertaining to patient care. Likewise, the administrative staff should meet at intervals with the medical staff. Success traditionally results from cooperative and enthusiastic team work.

In surveillance it must be remembered that hospitalized patients need care 24 hours a day, 7 days a week. This matter involves the medical staff, the administrative corps and the Board of Trustees. Can a 9 to 5 administrator, confined to his office, know his institution? Can a once-a-month trustee, the recipient of Red Carpet treatment, understand the problems? Can the chief of staff and the department heads and committee members know about the quality of the medical services from morning rounds only?

In surveillance one should recognize the potential of conflicts or prejudices. The medical staff member views the issue as it relates to his practice. The administrator, in facing problems, has his position and professional status at stake. The trustee cannot escape the desire for a proper image through his civic role and personal contributions.

The purpose of surveillance is to document the quality of medical services, to protect the public's interests, to cooperate in the enhancement of the institution's image, and to foster continuously education in medical sciences.

Summary

The goal of surveillance is to assure the public quality of care and services provided by the hospital.

Surveillance properly executed will be a run-

ning or continuous inventory for the Governing Board, administrative corps, and the medical staff.

Surveillance is a means of providing information to refute the false accusations too often woven from shoddy rumors and perpetuated, so it seems, by opponents of good health care.

The principles of surveillance are sound but the areas involved and methods of execution will change to keep abreast with progress. Potential areas for evaluation in the future may be accommodations, patient placement, traffic of patients, environmental matters, visitors, efficient construction and service traffic.

The tissue committee may become a new committee that will evaluate all medical care, laboratory and ancillary services. The medical records committee is still needed.

Relative to surveillance are: 1)"outside audit," 2)observation space in each operating room and birthroom for physicians and nurses, 3)betterment in staff appointments, 4)insurance for those serving the hospital, and 5)communications and meetings of representatives of the medical staff with the Governing Board and with the administrative staff. Sur-

veillance for tomorrow will surely witness joint operations in some areas by the administrators and professional staff.

Let us recall that more and better hospitals are being built yearly in this country than anywhere in the world.

History reveals that the more the self policing through voluntary agencies as the joint Commission on Accreditation of Hospitals, the easier duties are fulfilled and the more rapid the progress. Unless we continue to assure the public and meet our own demands for upgrading medical services, governmental departments by regulation or legislators by laws will direct us. Evolving surveillance is essential. Accreditation by the Joint Commission on Accreditation of Hospitals is as American as baseball, is as respected as law and order, and is as noble as a hero.

Our primary concern is the patient—his mental, emotional, religious, and physical well being.

Surveillance, appropriately planned and superbly executed is an essential factor in the fulfillment of our goal and serves the purposes of hospitals, hospital boards and medical staffs.

OPPOSITION TO OPPOSITION

Professional medical societies were asked recently to end their blanket opposition to all self-medication because it will "only lead to bootleg" use of potentially harmful home medical remedies.

Americans, as well as people throughout the world, have an "instinct to self-medicate" that is too strong to be legislated out of existence, a symposium sponsored by The New York Academy of Sciences was told. Gilbert H. Weil, a prominent New York attorney, lauded Congress' wisdom in trying to make the use of non-prescription drugs safe when taken as directed. He participated in a symposium on "Home Medication and the Public Welfare," held at the Waldorf-Astoria Hotel by the Academy's Section on Biological and Medical Sciences.

Mr. Weil urged organized medicine to follow Congress' approach and "accept self-medication as a fact of life and implement rather than attempt to frustrate it.

"This calls for evaluating the kinds of circumstances and types of disorders in which people are most determined to self-medicate. Then, make available the best information and drugs and devices possible for their use in such conditions.

"Failing that, they will only rely upon misinformation and resort to less effective and more harmful procedures," Mr. Weil stated.

NEW PRODUCT ABSTRACT

SUCCESSFUL USE OF A HEART-LUNG RESUSCITATOR FOR PROLONGED EMERGENCY RESUSCITATION AND TRANSPORTATION

Archer S. Gordon, M.D., Ph.D.,
and Carl Hewson

Cardiovascular Surgery Section, Lovelace
Clinic and Foundation, Albuquerque, New
Mexico.

Brunswick Manufacturing Company, North
Quincy, Massachusetts.

MOUTH-TO-MOUTH BREATHING and external cardiac compression can provide immediate and effective artificial respiration and artificial circulation for resuscitation emergencies which occur away from medical facilities, as well as in the hospital. The combination of these technics is known as *Heart-Lung Resuscitation*. It has been studied extensively in the laboratory and used successfully both inside and outside of the hospital to resuscitate victims of cardiac arrest resulting from drowning, suffocation, electrocution, heart attack, overdosage of drugs, etc. Heart-lung resuscitation consists of three relatively simple but important steps used in the following important sequence:

A—AIRWAY opened by tilting head into maximum extension.

B—BREATHING restored by mouth-to-mouth resuscitation.

C—CIRCULATION restored by external cardiac compression.

However, actual resuscitation experiences and further laboratory studies have conclusively demonstrated a number of additional important points:

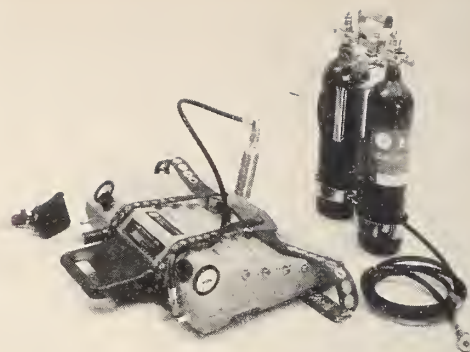


FIGURE 1. The complete Heart-Lung Resuscitator (H-L-R) assembly which provides:

A—AIRWAY opened by shoulder lift which tilts head back into maximum extension.

B—BREATHING restored by adjustable volume-cycled resuscitator.

C—CIRCULATION restored by adjustable external chest compressor.

Unit is completely portable and operated solely by oxygen from small Oxygen Pack (shown), large oxygen cylinders, or wall oxygen outlets.

Heart-Lung Resuscitator—25 pounds

Oxygen Pack with Tanks—25 pounds

I. Whereas, mouth-to-mouth breathing can be performed satisfactorily by first aiders following minimal training, properly performed heart-lung resuscitation requires careful and diligent training and periodic retraining of medical and paramedical personnel. Training manikins should be used and retraining sessions should be held at least every six months during the first two years and annually thereafter.

II. Although wide variations of technic have been recommended, it is important to adhere to specific details of performance in order to achieve optimum blood pressure, blood flow and blood oxygenation during emergency heart-lung resuscitation. When there are two operators:

1. External cardiac compression should be performed at a rate of 60 times per minute (80 to 100 times per minute for small children) with a 50:50 ratio of compression to relation and adequate pressure over the lower one-half of the breastbone to move it $1\frac{1}{2}$ to 2 inches.

2. The lungs should be inflated 10 to 12 times per minute (20 times per minute for small children).

3. Lung inflation should be "interposed" between each five chest compressions (5:1 ratio).

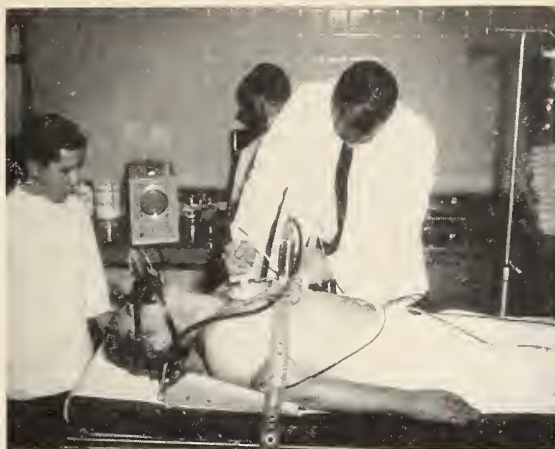


FIGURE 2. Heart-Lung Resuscitator (H-L-R) used in hospital emergency room for elsewhere in hospital. In cases of ventricular fibrillation, use of the unit is continued during external DC defibrillation. Note that no one touches the patient during defibrillation.

With practice, this can be done without a pause in the rhythm of external cardiac compression.

When there is only one rescuer, the lungs should be inflated two times after each fifteen chest compressions (15:2 ratio). This is not as good as the 5:1 ratio of compression to ventilation, but it is the best that can be provided under these circumstances.

III. Urgency in starting resuscitation has always been stressed, but it appears to be equally important to stress that heart-lung resuscitation must be performed uniformly and without interruption, especially when prolonged resuscitation is required. In order to stress these facts,

FIGURE 4. Pressure tracing taken from airway of patient during use of Heart-Lung Resuscitator. It shows volume-cycled lung ventilation "interposed" between each series of five external cardiac compressions.

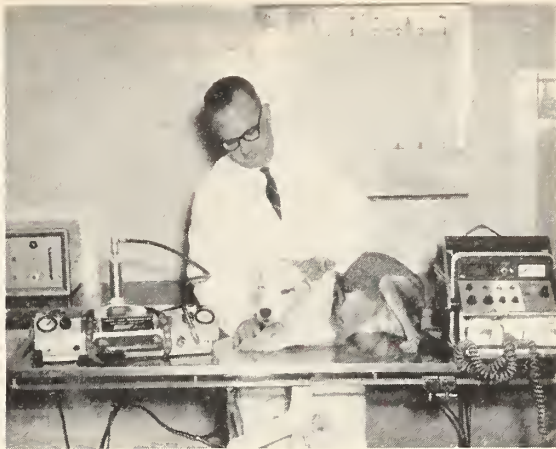
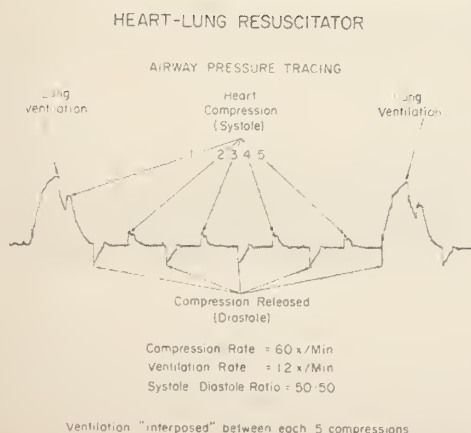


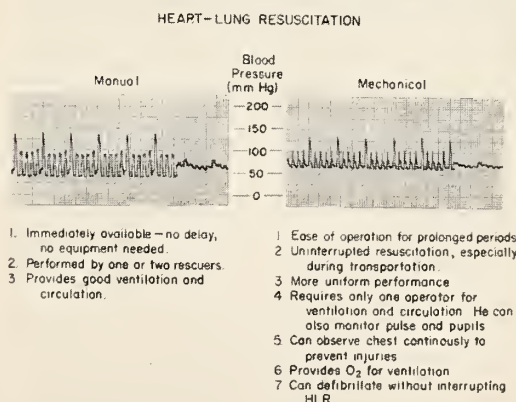
FIGURE 3. Dr. Archer S. Gordon, head of cardiovascular research, Lovelace Clinic and Lovelace Foundation for Medical Education and Research, Albuquerque, New Mexico, in the laboratory with one of the experimental animals on which the Heart-Lung Resuscitator and DC Monopulse Defibrillator were used. Lethal ventricular fibrillation was induced in dog's heart by an electric shock after which he was kept alive for more than two hours with no treatment except use of the Heart-Lung Resuscitator. The heart was then defibrillated with the DC Monopulse Defibrillator and the animal made a complete and rapid recovery to normal. Dr. Gordon played a major role in the development of the Heart-Lung Resuscitator, which is distributed by Medical Supply Co., Rockford, Illinois.

we emphasize the "Five Rules of Five":

Five Rules of Five

1. Always begin resuscitation in less than 5 minutes.

FIGURE 5. Blood pressure tracings taken during manual and mechanical heart-lung resuscitation on the same experimental animal with induced ventricular fibrillation. The manual technic must be applied immediately. When available, the mechanical Heart-Lung Resuscitator (H-L-R) provides distinct advantages, especially when prolonged resuscitation or transportation of the patient is required.



1. Immediately available — no delay, no equipment needed.
2. Performed by one or two rescuers.
3. Provides good ventilation and circulation.
4. Requires only one operator for ventilation and circulation. He can also monitor pulse and pupils.
5. Can observe chest continuously to prevent injuries.
6. Provides O₂ for ventilation.
7. Can defibrillate without interrupting HLR.

2. Begin with 5 good breaths of mouth-to-mouth resuscitation.

3. If no response, pupils dilated and pulse absent, begin heart-lung resuscitation using 5 basic steps:

- Lift neck
- Extend head
- Pinch nose
- Inflate lungs
- Compress chest

4. Inflate lungs after each 5 compressions.

5. Never interrupt heart-lung resuscitation for more than 5 seconds to move patient, intubate patient, administer drugs, check vital signs, defibrillate, etc.

IV. For prolonged heart-lung resuscitation and/or transportation of the patient, mechanical devices may be useful. However, these should not be of the ordinary pressure-cycled resuscitator design. Such units cycle every time the chest is compressed. Ventilation is not interposed and the lungs are not ventilated adequately, even with the use of the usual manual over-ride. Periodic pauses in external cardiac compression to allow adequate lung inflation by such devices seriously impairs the effectiveness of heart-lung resuscitation.

V. If a mechanical H-L-R is to be used when prolonged resuscitation or transportation of the patient is required, it should include the following basic features:

1. Provide for all three of the ABC's of emergency heart-lung resuscitation, as indicated above.

2. Perform as detailed under II, above.

3. Volume-cycled lung inflation interposed between chest compressions.

4. Adjustable controls for both lung inflation and chest compression.

5. Independent control of artificial respiration and artificial circulation so that unit can be used for artificial respiration only, as well as for combined heart-lung resuscitation.

6. Completely portable in size and weight so that it can be brought directly to the patient and carried with him on the stretcher while in operation.

7. Completely self-contained for field use (i.e., powered by portable oxygen cylinders, only).

We have now developed a mechanical H-L-R which has all of these characteristics.

It has been studied extensively on experimental animals (See Figures 6-10), tested on volunteer subjects and applied successfully on patients. A training movie has also been prepared demonstrating how this H-L-R performs and how it can be used in resuscitation emergencies to replace mouth-to-mouth breathing and external cardiac compression with less than five seconds interruption in the technic.

In laboratory studies, H-L-R has been used continuously for over two hours on a series of experimental animals in which lethal ventricular fibrillation of the heart has been induced with an electric shock. No drugs or other treatment was given to these animals during the period of ventricular fibrillation. Without emergency resuscitation, they would have been dead or suffered irrevocable brain damage within four to five minutes. However, after two hours use of the H-L-R, they were given emergency drug therapy (adrenalin and sodium bicarbonate) and defibrillated with a single external shock of 125 Watt seconds from a DC Monopulse Defibrillator. These animals then made rapid and complete recoveries without clinical evidence of brain damage from the ventricular fibrillation or injury from the H-L-R.

Physiological data collected during these studies revealed that the level of oxygen in the blood was always maintained at normal levels throughout this period and that the mean blood pressure in the carotid arteries to the brain was 50% of normal and the mean blood flow to the brain was 25% to 33% of normal. The pH of the blood (acid-base balance) dropped precipitously throughout the period of resuscitation from a normal level of 7.4 to a low of 6.8. Levels below 7.0 are usually considered incompatible with survival.

The H-L-R has now been used in hospital emergency rooms and on the wards and intensive care units primarily for post-operative heart surgery patients and patients with coronary heart disease. It has been used successfully for periods up to 45 minutes, although the patients so treated have only lived from 1 hour to 3 weeks following resuscitation. Extension of its use in the hospital—and to highly trained ambulance and rescue groups outside the hospital—should improve this record by allowing application sooner and on good risk patients.

COMMITTEE ON MEDICAL ECONOMICS REPORT

REPORT ON RETIREMENT INVESTMENT PROGRAM

THE BOARD OF TRUSTEES of the Illinois State Medical Society and the Committee on Medical Economics have approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The group annuity and mutual fund portion of the Program may also be used as funding vehicles for Keogh qualified investment if so desired. The Keogh qualified plan, known as the Illinois State Medical Society *Tax Qualified Retirement Program*, utilizing a legally required trust, will be described in greater detail in a subsequent Journal article. The Tax Qualified Retirement Program and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The Group Annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the Mutual Fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Ill. State Medical Society. By doing so he not only receives advantages he would not otherwise have but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Plan*, making available the Group Annuity at a substantial reduction in premium, and the Mutual Fund, offered without sales commission load, is one of the most recent of its kind and was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the Group Annuity and the Mutual Fund, and the retirement age are determined by the participating physician.

The Continental Illinois National Bank and Trust Company of Chicago receives all physicians contributions, maintains records, and forwards payments designated by the participant to the Insurance Company and the Mutual Fund. Receipts are then mailed to physician participants for all payments showing the balance and the due date of the next payment.

Group Annuity

The Group Annuity, underwritten by the Continental Assurance Company, participates in dividends which are reinvested annually at compound interest.

The Group Annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity whichever is greater. Initial guarantees provide up to \$10,000 insurance death benefit which is issued regardless of prior medical history.

Six options for settlement at retirement are available under the annuity. The most frequently chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance, is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary if he elects a life income and dies shortly after retirement.

Mutual Fund

The no load open end Mutual Fund, consisting primarily of common stocks, is managed by Stein Roe & Farnham of Chicago, who has

been serving as investment adviser to pension and profit sharing trusts, trustees, individuals, and other investors since 1932.

The Stein Roe & Farnham Stock Fund is quoted daily in most major newspapers and the WALL STREET JOURNAL. The Fund has no sales commissions. The investment adviser receives a quarterly management fee of $\frac{1}{2}$ of 1 per cent of the average net asset value of the Fund. Management fees are common to all mutual funds and are distinct from sales loads.

Members wishing additional information on the Society's sponsored program may write to:

Illinois State Medical Society
c/o Continental Illinois National Bank
and Trust Company of Chicago
Corporate Securities Division
Chicago, Illinois 60690

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EPIDEMIC YEAR FOR GERMAN MEASLES

Latest figures released by the National Disease and Therapeutic Index shows visits for German measles reached epidemic proportions in the first six months of 1964. Physicians received an estimated 1.8 million visits for German measles since January of this year. This represents almost a 500 per cent increase over the same period last year.

A regional breakdown shows that 1964 rubella visits were higher than average in the East, particularly in the New England and Middle Atlantic states. The Eastern half of the country usually accounts for 25 per cent of all visits to private practitioners; rubella visits showed 36 per cent in this region.

An age breakdown on German measles visits showed that the epidemic was confined almost entirely to children and teen-agers, with only about 1/5 of the visits being accounted for by adults. The sex breakdown for rubella was about average with females accounting for approximately 60 per cent of the visits to private physicians.

PUBLIC HEALTH
ANNOUNCEMENT

A NEW STANDARD FOR
CALIBRATION OF
AUDIOMETERS

EFFECTIVE JANUARY 1, 1965 the reference levels for pure tone audiometers will be changed. This new standard which has been agreed upon and recommended by the International Organization for Standardization (ISO) will establish a different relation between the number of decibels (dB) on the dial of an audiometer and the physical intensity of the sound that the instrument produces. The Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology and the Executive Council of the American Speech and Hearing Association have voted to adopt this new standard (ISO 1964) to replace the old standard (ASA 1951).

The new ISO levels differ from the American Standard Association values of 1951 which presently constitute the basis of our rules and laws for calculating percentage impairment of hearing for compensation purposes. A second area which will be affected significantly is hearing screening programs which are conducted in our school systems. It will be necessary to readjust mental standards as well regarding what constitutes normal limits of hearing, a significant hearing loss, etc.

As of January 1, 1965 the majority of audiometer manufacturers will begin production using the new standard. New audiometers will be clearly marked "Hearing Threshold Level—

ISO 1964." Upon request, old audiometers returned for recalibration will also be labeled with this designation.

Finally, journal and technical publications will employ the new standard beginning January 1, 1965.

In order to facilitate the orderly transition from one set of reference levels to the other, the following procedures are recommended:

1. When reporting decibel levels in writing, care should be taken to note whether the levels are based on the ISO or ASA standard.

2. On an audiogram form, the verticle scale should be designated "Hearing Threshold Level in dB." During the transitional period, the horizontal scale should be labeled as follows:

Frequency, C/S

125 250 500 1000 1500 2000 3000 4000 6000 8000

Difference in dB

(1964 vs. 1951)

9 15 14 10 10 8.5 8.5 6.0 9.5 11.5

3. The audiogram form should include the following notations:

This audiogram is plotted on the basis of:

☐ 1964 ISO reference thresholds

☐ 1951 ASA reference thresholds

(Check one of these squares)

Readings obtained on an audiometer calibrated to the 1951 ASA thresholds may be converted to, and plotted as, "Hearing Threshold Levels" based on the 1964 ISO reference thresholds by *adding* the appropriate "Difference in dB" at each frequency. To convert readings based on the 1964 ISO reference thresholds to readings based on the 1951 ASA reference thresholds *subtract* the "Difference in dB."

For background information and discussion of this matter, you are referred to the article entitled, "The International Standard Reference Zero for Pure Tone Audiometers and Its Relation to the Evaluation of Impairment of Hearing. This article appeared in the Journal of Speech and Hearing Research, March 1964, pp 7-16.

NEW PRODUCT

In 12 of 22 ambulatory patients with moderate to moderately severe hypertension, blood pressure was reduced to normal or near normal levels by administration of polythiazide alone.

IT IS NOW GENERALLY agreed that the benzothiadiazine diuretics are effective agents in the treatment of arterial hypertension, but until recently only a modest hypotensive effect had been attributed to them. Therefore they are most often used in conjunction with other hypotensives which means the exposure of the patient to the undesirable side-effects of more

than one drug. Only a few observations have been reported on their use as a sole hypotensive agent. Among these Freis et al.¹ and Finnerty et al.² both found moderate reduction of blood pressure in mild and moderate hypertension, while Achör et al.³ and Hoobler⁴ reported that significant lowering of the blood pressure can be achieved with a benzothiadiazine alone even in cases classed as moderately severe. Chlorothiazide was effective in 30% of patients with mild to moderate hypertension observed by Gifford.⁵ Studying the effect of prolonged therapy with various single agents (reserpine, hydralazine, chlorothiazide and mecamlamine) Cottier⁶ found that after treatment for at least four weeks chlorothiazide was most effective in reducing recumbent blood pressure. Recently Griebel and Johnston⁷ found a modest but significant decrease of blood pressure in most of their patients with "moderate to severe" hypertension, treated by prolonged administration of bendroflumethiazide. Similar results were reported by a co-operative group of Veterans Administration Hospitals⁸ on the hypotensive effect of Chlorothiazide in "mild to moderate" hypertension.

This paper is our report on our experience on the *prolonged* use of a benzothiadiazine drug (Polythiazide),* which we attempted to use as a sole antihypertensive agent.

Material and Method of Study

Twenty-five ambulatory patients with persistent hypertension of unknown etiology were originally included in this study in our out-

*The polythiazide used in this study was supplied as Renese by Chas. Pfizer and Company, Inc.

TREATMENT OF HYPERTENSION WITH POLYTHIAZIDE: ITS USE AS THE SOLE ANTIHYPERTENSIVE AGENT

Imre E. Horner, M.D. and
Arnold M. Tatar, M.D./chicago

From the Department of Medicine and the Renal Clinic of Michael Reese Hospital and Medical Center, Chicago, Illinois.

Senior Attending Physician, Department of Medicine, Chief, Renal Clinic, Michael Reese Hospital and Medical Center, Chicago.

Assistant Attending Physician, Department of Medicine, Michael Reese Hospital and Medical Center, Chicago.

TABLE 1

Case No. Age Sex	Average b.p. before any medication	Previous medication (mg./day)	Average b.p. on previous medication	Average b.p. during untreated period	Medication during present study	Average b.p. during b.p. study	Average b.p. during untreated period
1. 36 F	210/135	Reserpine 0.75	180/120	240/130	Polythiazide 4	165/90	
2. 43 F	200/110	Reserpine 0.5	170/113	180/115	Polythiazide 4	123/85	
3. 40 F	170/120	Chlorothiazide 1000	160/120	180/130	Polythiazide 4	143/90	
4. 43 F	220/120	Chlorothiazide 1000	180/105	200/120	Polythiazide 4	175/95	
5. 38 F	160/118	Chlorothiazide 1000	110/75	140/100	Polythiazide 2	118/87	
6. 51 F	180/110	Reserpine 0.5	165/96	210/115	Polythiazide 4	160/95	
7. 56 F	190/110	Chlorothiazide 500	160/90	170/115	Polythiazide 4	143/97	
8. 45 F	190/100	Chlorothiazide 1000	140/90	170/110	Polythiazide 4	166/104	
9. 57 F	212/124	Reserpine 0.5	215/125		Polythiazide 4	163/96	
10. 57 M	180/110	Reserpine 0.75	170/108		Polythiazide 4	133/85	
11. 46 M	240/120	Reserpine 0.5	200/109		Polythiazide 4	184/113	
12. 30 F	160/110	None			Polythiazide 4	117/77	
13. 55 F	190/110	None			Polythiazide 4	144/83	
14. 61 F	190/108	None			Polythiazide 4	187/102	
15. 57 F	236/130	Chlorothiazide 500			Reserpine 0.25	145/92	
16. 50 F	182/120	Chlorothiazide 1000			Hydralazine 75	134/92	
17. 46 F	240/130	Chlorothiazide 1000			Guanethidine 50	220/130	
18. 48 M	220/120	Reserpine 1.0			Reserpine 1.0	165/96	
19. 29 F	170/100	Reserpine 0.5			Chlorothiazide 1000	165/85	
20. 47 M	180/130	Chlorothiazide 1000			Reserpine 1.0	165/125	
21. 50 F	220/130	Chlorothiazide 500			Reserpine 0.5	220/115	
22. 58 F	260/135	Chlorothiazide 500			Reserpine 0.75	198/105	
		Hydralazine 100			Hydralazine 100	179/100	

TABLE 2

Patterns of serum constituents in 22 patients.									
	Before Polythiazide administration			During Polythiazide administration			Analysis of changes		
	Range		Average	Range		Average	Increase	Decrease	Unchanged
Sodium (mEq/L.)	135	- 148	142	134	- 145	140	0	0	22
Potassium (mEq/L.)	3.2 - 6.0		3.8	2.6 - 4.6		3.8	1	13	8
Chloride (mEq/L.)	87	-105	100	88	-102	96	0	3	19
CO ₂ (mM/L.)	23	- 35	28	23	- 37.6	31	15	0	7
pH	7.21-	7.40	7.36	7.29-	7.47	7.37	2	1	19
Urea N (mg.%)	10	- 44	17.5	9	- 38	19	5	1	16
Uric acid (mg.%)	4.0 - 9.5		5.8	3.7 - 10.6		7.1	13	2	7

patient department. Twenty were females. With the two exceptions, all were Negro. Their ages ranged from twenty-nine to sixty-five. Their diastolic blood pressures ranged from 95 to 146, with a mean of 118. Patients with labile hypertension or with grossly impaired renal function were excluded. The known duration of hypertension varied from nine months to seventeen years. Grade I or II hypertensive changes were found in the retinal vessels in all cases, often combined with arteriosclerotic changes.

Three patients were withdrawn from the study for reasons that may or may not have been related to the polythiazide. One developed a severe headache a few minutes after taking the first dose and refused further medication. The second complained of numbness of the lips and weakness. The third patient, who had a past history of hemiplegia, developed some signs of cerebrovascular insufficiency after a few doses of polythiazide but before any reduction of blood pressure had occurred.

The patients were examined weekly for the first few months, and then at intervals of two or three weeks. Every patient was followed for a minimum of three months on polythiazide, and many for over six months. The tabulated blood pressures were taken consistently in the same arm with the patient in sitting position. Blood pressures were also checked in the opposite arm, the lower extremities, and in standing and recumbent positions when it seemed necessary. Large cuffs were used if the patient was very obese.

Serum sodium, potassium, chloride, CO₂ content, pH, urea nitrogen, and uric acid were all determined (a) before polythiazide administration, (b) after one week of polythiazide, and (c) at two to three week intervals thereafter.

Whether used alone or in combination with other medication the initial dosage of polythiazide was 4 mg. daily, given in two 2 mg. doses; maintenance dosage was lowered whenever blood pressure response permitted. In case #17, a patient weighing 240 pounds, the daily dose was raised to 8 mg. (4 mg. twice daily when the initial dosage failed to bring about the desired effect.

No alterations in activity, living habits, or diet were advised, and no potassium supplements were prescribed. The patients were advised to drink one glass of orange juice or to eat one banana daily.

If the patient has been previously treated with one or more antihypertensive drugs, this treatment was discontinued and changed to polythiazide alone. In Cases #1 to 8 this was done after a period of two weeks to two months, during which the patient received no medication. In Cases #9, 10 and 11 such interruption seemed inadvisable on the basis of the previous course of the disease. Patients who had never received any treatment for hypertension, were started on polythiazide alone. (Cases #12 to 14.) In patients #15 to 22 abrupt change from a combination of drugs to polythiazide alone seemed inadvisable and in these cases the transition was gradual. When normal

pressure was achieved with the polythiazide-containing combination (Cases #15, 16, 17 and 19), an attempt was made to maintain it with polythiazide alone.

Results

The changes in arterial pressure during this study are summarized in Table 1. The arterial pressure was reduced significantly in seven of the eight patients whose previous treatment was discontinued for a period ranging from two weeks to two months and then resumed with polythiazide alone. (Cases No. 1 to 7.) The average difference in the blood pressure observed during the untreated period and during treatment with polythiazide was 40/23, ranging between 70/35 and 20/7. In patient #8 the result with polythiazide alone was unsatisfactory.

Significant further decrease of blood pressure resulted from changing from a combination of drugs to polythiazide alone in two of the three patients (Cases No. 9 and 10) in whom this was done without interruption of the previous treatment. In one patient (Case #11), the result with polythiazide alone was unsatisfactory.

Among the patients who had never been previously treated, the decrease in blood pressure on polythiazide administration was 43/33 and 46/27 respectively. (Cases #12 and 13). In Case #14 the reduction was slight.

In a group of eight patients in whom polythiazide was either added to the previous regimen or substituted for the previous medication, further reduction of blood pressure was attained in six, (Cases #15, 16, 17, 18, 20 and 21). In two patients (Cases #19 and 22), there was no significant change.

Effect on Various Constituents in the Serum

The most consistent deviation from normal was the moderate increase in CO₂ content which occurred in fifteen of the twenty-one cases. Hypokalemia and hyperuricemia both occurred in thirteen of the cases; paradoxically, potassium rose in one case, and uric acid fell consistently on serial determinations in two cases. Elevation of CO₂ content was not always associated with hypokalemia. Moderate elevation of serum urea nitrogen occurred in

five cases. In only three cases was hyponatremia observed, the lowest value being 88. Serum sodium remained within normal limits in all cases. The hypokalemia, hyperuricemia, and hypercapnia were all asymptomatic. No correlation could be found between the levels of any of the electrolytes and to the antihypertensive response to polythiazide.

These findings are tabulated in Table 2.

Effect on Body Weight

This was studied most closely in our nine obese patients, seven of whom were female. Significant weight loss was observed in three, no change in five, while one patient gained four pounds (from 206 to 210). This weight gain occurred as the patient's blood pressure decreased from 220/115 to normal (Case #21).

Since significant reduction of blood pressure was obtained in all obese patients, no parallelism between weight loss and hypotensive effect of polythiazide could be found.

Postural Effects

No consistent pattern could be discerned in the blood pressures taken in the supine, sitting, and standing positions. In some cases the antihypertensive effect was more marked in the supine, in others in the standing position, while in most the pattern changed from one visit to the next.

Side Effects

Side effects were observed in four of the twenty-two cases. One patient complained of transitory nausea, while another had transitory blurring of vision and some dizziness. Epigastric discomfort occurred in two patients, without any physical findings or elevation of serum amylase; polythiazide was temporarily discontinued, and then resumed without reappearance of the discomfort previously attributed to the drug.

Duration of Antihypertensive Effect

Inadvertently, patients whose supply of polythiazide was exhausted at varying intervals be-

(Continued on page 72)

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for good results
in a wide variety
of infections

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As compared with demethylchlortetracycline, chlortetracycline and tetracycline, Terramycin offers the additional advantage of the highest

96-hour urinary recovery rate. It has also been demonstrated that Terramycin has the lowest degree of protein-binding and the highest relative distribution volume¹—reflecting fast, free movement into body tissues and fluids.

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Ahead of its time for 14 years, Terramycin remains a broadly effective and dependable antibiotic with a fine record — confirmed by more than 6,000 published papers. Moreover, the incidence of serious adverse effects has been remarkably low.

1. Kunin, C. M. et al.: J. Clin. Invest. 38:1950, Nov., 1959.

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All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood

vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.

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for January, 1965

(Continued from page 67)

fore their return to the clinic, provided data on the duration of the antihypertensive effect. Interruption of therapy for one or two days had no apparent adverse effect on blood pressure, but longer intermissions usually resulted in relapses to hypertensive levels. Thus it seemed that the antihypertensive effect of the drug lasts at least 36, possibly 48 hours.

Discussion

Our data indicate that substantial reduction of both the systolic and diastolic blood pressure can be achieved not only in mild and moderate but also in moderately severe cases of essential hypertension with the administration of a benzothiadiazine alone, *if given a sufficiently prolonged trial*. We found, as did Cottier and Griebble and Johnson, among others, that the decrease in blood pressure achieved in the first few days is not maximal but may continue for weeks with persistent medication. Of the twenty-two cases studied eight had moderately severe hypertension with a diastolic pressure between 130 and 140 and the systolic up to 260. With one exception (Case #3) these patients had been previously treated with a combination of antihypertensive drugs. In five out of these eight patients, including some in whom previous treatment with a combination of drugs had been unsuccessful, (Cases #9 and 17), the blood pressure could be reduced to normal or near-normal (and maintained at that level) with the persistent use of polythiazide alone.

Of the fourteen cases with moderate hypertension (with the systolic pressure ranging between 160 and 240 and the diastolic between 100 and 120), seven were controlled by polythiazide alone. In the other seven reserpine had to be added to polythiazide. With this combination normal tension has been achieved in five cases and in two the blood pressure remained above normal.

We would like to emphasize that the results obtained with polythiazide do not necessarily indicate superiority of polythiazide over other thiazides. The prolonged use of this drug in a more adequate dosage is more likely to be responsible for the better results. It is also possible that the continuity of medication was better controlled, by more frequent visits to the clinic,

during this study. But regardless of the extent to which these latter factors contributed to the results obtained, the fact remains that rather severe cases usually thought to require a combination of drugs, have been satisfactorily controlled by polythiazide alone.

As to the mechanism of the hypotensive effect of the benzothiadiazines, we would draw no conclusions from our observations except, perhaps, in a negative sense. Contrary to the observations of others we could not correlate the changes in blood pressure with those in the serum electrolytes. The fact that our results were obtained in patients with unlimited salt intake seems to speak against the theory which attributes the hypotensive effect of these drugs to salt loss or to hypovolemia concomitant to the salt loss.

Conclusions

We came to the conclusion that the rational approach to the treatment of moderate or moderately severe hypertension is to use a benzothiadiazine first and only if satisfactory reduction of blood pressure has not been obtained after at least four weeks of continuous use of these drugs in sufficient doses, should other drugs be added to the regimen. In many cases the addition of reserpine will be sufficient and when it is not, hydralazine should be the next addition. Guanethidine will be only exceptionally necessary in cases without Grade III or IV retinopathy. Even in patients requiring a combination of drugs to normalize the blood pressure, once this has been achieved, a benzothiadiazine drug alone may be sufficient to maintain the blood pressure on an acceptable level. The extension of the role of the benzothiadiazines in treatment of hypertension should result in great reduction in the need for a combination of drugs and, thereby, in the reduction of the undesirable side effects.

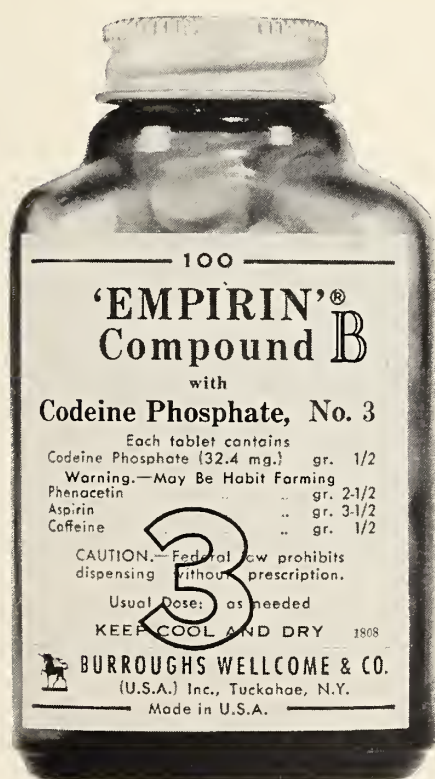
Summary

In twelve out of twenty-two ambulatory patients with moderate to moderately severe hypertension the blood pressure was reduced to normal or near-normal level by prolonged administration of polythiazide alone. In eight other case only the addition of reserpine to the

(Continued on page 74)

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(Continued from page 72)

regimen was necessary to obtain the desired results. Hypotensive response to the drug was unrelated to changes in the serum potassium or in any other electrolytes. These changes, as well as those in the serum urea nitrogen and serum uric acid, were similar to those observed with the use of other benzothiadiazine drugs. Side effects were infrequent and of little clinical significance.

As a rational treatment of moderate or moderately severe case of hypertension the use of a thiazide alone for at least four weeks is recommended, with the addition of other hypotensive agents only if the result is unsatisfactory at the end of this period.

Acknowledgement

We are indebted to Dr. Jack Sloan, Dr. Wilfred Wise, Dr. Jerome Neustadt, and Dr. David Edelbaum, for their participation in this study, and to Dr. Morris Weiss, Medical Director of

the Babette and Emanuel Mandel Clinic for coordinating the liaison between clinical and laboratory studies.

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'63 DRUG SALES

Sales of ethical drugs—prescription and over-the-counter products advertised only to the health professions—exceeded \$2 billion in the U.S. for the first time in 1963, according to the Bureau of the Census.

All drug industry sales were \$2.95 billion, five per cent above 1962, the bureau said. It reported the ethical figure at \$2.05 billion, 5.4 per cent over the previous year.

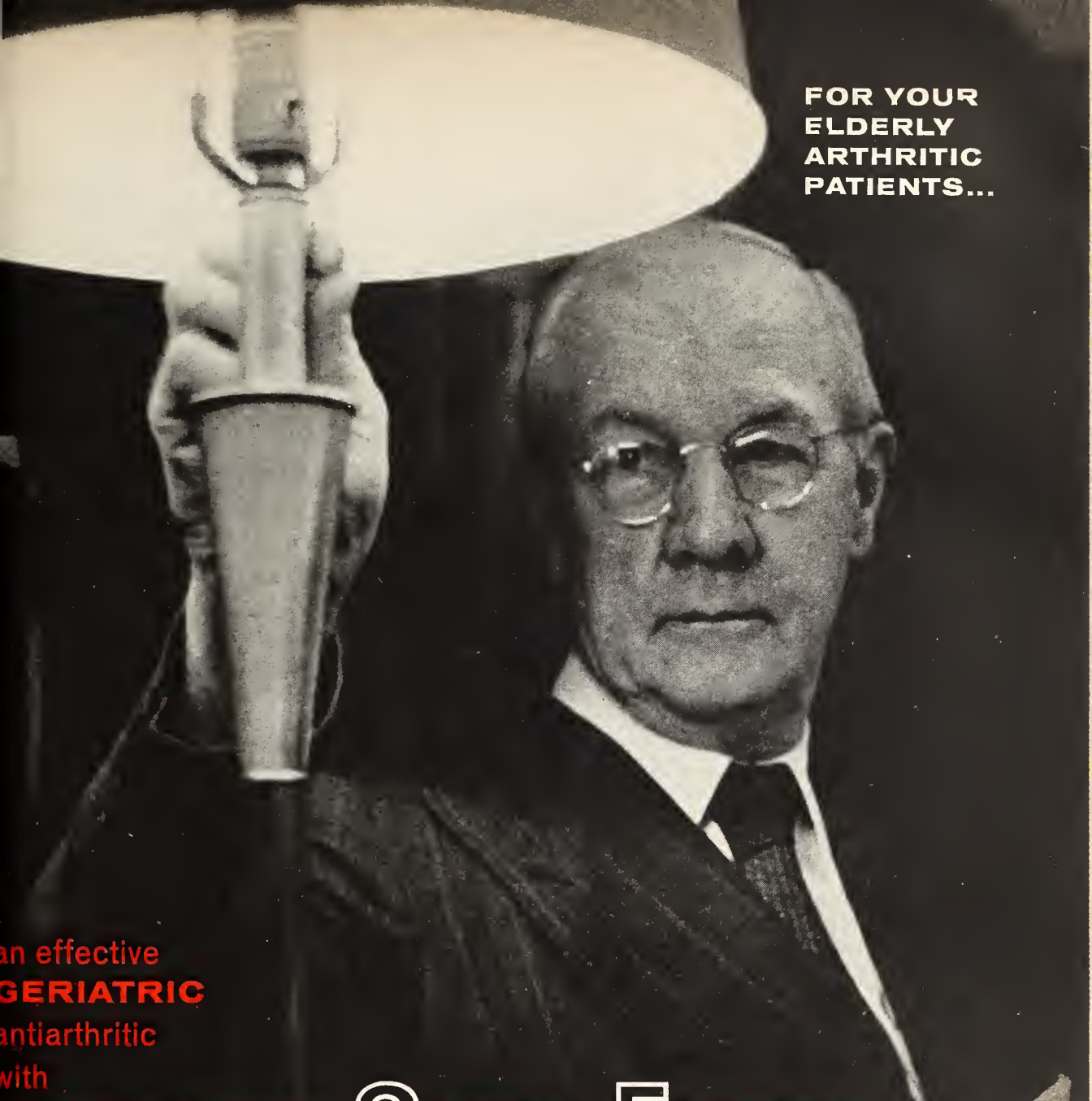
The Pharmaceutical Manufacturers Association said the domestic sales figure reported by Census was about \$300 million less than its own figure of \$2.39 billion. PMA said the Census Bureau excluded about \$165 million worth of biologicals in its report.

Census and PMA employed several other varying means of interpreting sales and this accounts for the remaining difference in the two figures.

The report by the census bureau is its second in a new series on pharmaceutical industry sales. Census treated separately the sale of proprietary drugs but said the 1963 volume was \$803 million, up 4.9 per cent from the 1962 level of \$766 million.

PMA said census figures over the years show that sales of human ethical preparations increased by 83 per cent between 1954-63; a reduction in the 109 per cent increase reported for the period 1947-54.

According to the figures from the census bureau, "drugs acting on the central nervous system and sense organs" lead all others in sales volumes.



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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

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ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT



"The Newsletter", official bulletin of the Illinois Medical Assistants Association, won a second place trophy at the recent AAMA convention, topped only by the bulletin from Texas. Co-editors of the IMAA "Newsletter" are Thelma Peplow and Ethel Pedersen from Sycamore, Illinois. Associate Editors are Janet Ellsworth and Lina Trotter. IMAA is very proud of this honor and especially proud of its editors and news correspondents from the

component chapters who have made this possible. The Bulletins from the various States are judged as follows:

Educational Articles	50%
Programs	25%
Projects	10%
Art Work	5%
Neatness & Originality	10%

The IMAA "Newsletter" contains many things among which are (1) News from component chapters regarding their activities, which helps other chapters enlarge the scope of their chapters by exchange of ideas; (2) Educational articles, which assist the Medical Assistant to broaden the scope of her medical education; (3) Legislative articles, which assist the Medical Assistant to broaden the scope of her legislative education—which is particularly important right now; (4) News of IMAA importance such as special announcements etc.; (5) News of "After M.A. Hours" which assist the Medical Assistant in becoming better acquainted with her fellow Assistants and many many more items.

If your Medical Assistant is a member of IMAA she receives the "Newsletter". She would be happy to have her doctor read it. If she does not belong to IMAA have her ask a member for her copy. She will enjoy it and so will you.

We are so proud of our bulletin we would like to have every doctor in Illinois read it. It represents a lot of work for our co-editors but they do it willingly and gladly because they know it is very worthwhile for the members.

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Throughout the wide middle range of pain PERCODAN assures speed, duration, and depth of analgesia by the oral route plus the reliability that counts so much. PERCODAN acts within 5 to 15 minutes...usually provides uninterrupted relief for 6 hours or longer with just 1 tablet...rarely causes constipation.

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of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also Available:** PERCODAN®-DEMI, each scored pink tablet containing 2.25 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. *U. S. Pats. 2,628,185 and 2,907,768
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EDITORIALS

COMMENTARY ON A COMMENTARY

This letter is a commentary on a commentary—namely the opinion voiced in the *ILLINOIS MEDICAL JOURNAL* for October 1964 about the A.M.A.-N.E.A. publication *HEALTH EDUCATION*. This book, issued in its fifth and completely rewritten edition in 1961, now becomes the subject of a delayed disapproval from Mr. Lynford L. Keyes of the Illinois Department of Public Health.

The commentary begins with a reference to a Sahara, a wasteland in which there are no books, and likens this book to a hillock in comparison with the “alps” of non-existent books about school health education. This is a new wrinkle in book reviewing, aside from the fact that one wonders where the reviewer has been, in view of the many good books available for the use of the health teacher. The commentator overlooks another salient point, namely that such a book as *HEALTH EDUCATION*, produced by the two professions most intimately involved, is necessarily unique.

The book, says the reviewer, suffers from being bound to the past. This, in view of its complete rewriting—to which I can testify of my own knowledge, having been instrumental in this revision—is manifestly inaccurate. Even if it were not, what sort of guide-book can ignore the past? There is another statement to the effect that school health education has “unfortunately enjoyed little fresh thinking during the past ten years.” These are the years 1954-1964 in which five of the nine biennial Conferences on Physicians and Schools sponsored by the American Medical Association have been held. These Conferences together with many other influences, have brought a great deal of joint professional thinking to bear upon the many knotty problems involved in school health, and have brought many of them partway along the road to solution.

The commentary declares that book pays but scant attention to the increasingly vexatious problem of over-specialization in health education, when in fact the entire volume is dedicated to coordination, organization and the increase of effectiveness through cooperation of the entire health team in the schools. As to the charge that “any reliable, let alone standardized, progression of teaching health is yet to be established” and that “this does not seem to be recognized or dealt with in the 5th Edition”, one needs merely to note that Chapters 6 through 10, pages 116 through 276, are devoted exclusively to this topic, with other references touching upon it. True, the book does not call for *standardization*—it prefers the exercise of judgment by the qualified teacher.

The commentator believes that the book “bespeaks of (sic) the communications and conceptual gap which exists between writers of school health education books and those who might wish to use them.” This despite the listed names of the members of the sponsoring committee, the contributors and the consultants—62 distinguished leaders in health education, and others not named including a good many who use as well as write health books. It is to be regretted that the intensive and often self-sacrificing efforts of these dedicated persons should be cavalierly dismissed with a statement that this is a good book, but it ought to have been better.

The commentator does admit that the book “covers quite comprehensively the dimensions and concepts of school health education. There is a wealth information throughout the book. . . . Of note also are the up-to-date selected references at the end of each chapter. The photos are handled with sensitivity. . . .” But . . . “the dull style in which the book is written”. . . makes it “. . . difficult to find a student or grad-

uate who has read the book in its entirety or who refers to it with anything but distaste as a dull, laborious reference."

Well, the book is a reference book, like an encyclopedia or dictionary, not meant to be read consecutively but to be studied. Its authors did not have any Pulitzer prize for literature in mind. The usefulness of the book, admitted by the commentator, raises the question as to why it was deemed advisable by him, at this late date, to go to the trouble of discrediting a valuable piece of work, thus tending to limit its usefulness. This query is especially

pertinent in view of the acknowledgement; "When viewed in comparison with prevailing books on school health in the United States, this volume assumes notable proportions."

W. W. Bauer, M.D.

Director Emeritus, Department of Health Education, American Medical Association, Member and Secretary of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association 1932-47

TRAUMATIC-LESS HOSPITALIZATION FOR CHILDREN

How can hospitalization be made less traumatic for a child?

The Boston Floating Hospital for Infants and Children believes it may have the answer in a unique arrangement which allows the patient's mother to become a "bed-side" temporary member of the hospital care team.

The hospital, which is the pediatric unit of Tufts New England Medical Center, is trying the new concept in a pilot study financed by a federal research grant. Miss Geneva Katz, R.N., administrator of the hospital, describes the study in the current issue of *Hospitals*, Journal of the American Hospital Association.

At Boston Floating hospital, the child's mother is permitted to live in with the patient in one of four single rooms adjacent to a nursing care area.

Each room contains a crib or bed for the child, a studio couch for the mother, and a snack-stocked refrigerator, hot plate and toaster for the mother's personal use.

The mother works with the nursing and medical staff in a close relationship, Miss Katz says, providing many of the services for the child that the mother would normally at home.

From 5 p.m. to 8 a.m., the mother assumes full responsibility for the child, calling the nursing supervisor only if necessary. The mother's constant presence lightens the nurses' load, lowering hospital rates \$5 per day for the child, Miss Katz explains.

There is no charge for the mother's food or room, Miss Katz says. The father can replace the mother to give her time off.

The special units are apart from the regular wards to provide greater privacy. Children who are patients in the special section seem less restless, have better appetites, and are more content, Miss Katz writes.

Admissions thus far have been limited to medical and surgical, simple treatment, or diagnostic patients, although the hospital hopes to broaden its base of admissions to the units as confidence in the plan grows.

"We believe a mother usually is a capable 'nurse' when her child is ill at home," Miss Katz says. "In our program the mother's special abilities are coordinated with those of the nurse."

The project is being closely watched with the hope it will provide a new approach to better child care in the hospital of the future, the Journal reports.

APHASIA VICTIMS CAN SPEAK AGAIN

Each year more than 400,000 Americans suffer aphasia, one of the frequent results of stroke. Language skill and speech as well as memory usually will return quickly although sometimes it will require many months of painstaking training by a professional speech therapist or speech pathologist.

Key to full recovery is intelligent and sympathetic understanding and help by members of the family. Here are some suggestions adapted from "An Open Letter to the Family of an Adult Patient with Aphasia" written by a nationally recognized authority in the field, Miss Betty Horwitz, of New York, and published by the National Society.

1. Talk to the patient simply and naturally. Encourage him to respond in whatever way he can.

2. Do not ridicule or insist that responses be accurate, or correctly pronounced.

3. Do not speak to the patient as if he were a child or deaf or retarded.

4. Do not discuss his emotional reactions and problems in his presence.

5. Be natural with him and help him to maintain his former status in the family group.

6. Include him in all family affairs; consult with him and see that he shares in family decisions as he did before.

7. Don't tell him to relax. By your mannerisms, patience and attitude of acceptance, create an air of relaxation for him.

8. Explain what has happened to him.

To encourage the regaining of speech, Miss Horwitz, who holds advanced speech certification in the American Speech and Hearing Association, has these additional hints:

1. Keep instructions and explanations simple.

2. Ask direct questions requiring a simple "yes" or "no" answer.

3. Do not confuse the patient with idle chatter or too many people speaking at once.

4. Do not answer for him if he is capable of speaking for himself.

5. Utilize routine activities for speaking. Meals and dressing time are good opportunities.

6. Encourage the use of greetings and social exchanges such as "Hello," "Thank you," "How are you."

7. The patient who can write and spell should be encouraged to carry a pad and pencil so he can write what he cannot say.

8. Encourage gestures and talking with hands whenever and if possible.

9. Be prepared for bizarre, inaccurate use of language and for swearing. Accept this without amusement or anger.

10. Remember that a characteristic of aphasia is the inability to remember the names of people and objects. Reassure the patient that this is part of his sickness and that he is not "losing his mind."

The planning and administration of the teaching program at Grant has been under the guidance of Dr. Welker for the past several years in the capacity as the chairman of the Medical Education Committee. However, it was felt by the medical staff and members of the Board of Directors that with the complexity and rapid advances in medical knowledge, a permanent director of the department was needed.

Dr. Welker is a member of the American Academy of Pediatrics, Alpha Omega Alpha, and Sigma XI.

Dr. Welker is married to Dr. Joseph Greengard, Director of Medical Education at Cook County Children's Hospital. They have two daughters and one grandson.

Dr. Surrey has been honored by the New York State Junior Chamber of Commerce, which presented him with a Distinguished Service Award for the development of Aralen during World War II. He has also received the Winthrop Order of Merit in recognition of his sci-

entific achievements. These include Plaquenil, a drug used in arthritis, and Trancopal, a muscle relaxant. The award was established by Winthrop Products Company, a division of Sterling-Winthrop Group Ltd., the United Kingdom subsidiary of Sterling Drug.

Dr. Surrey joined what is now Winthrop Laboratories in 1941 as a research chemist, continuing in that position with the Sterling-Winthrop Research Institute upon its formation in 1946. In 1956 he was named section head and in 1961 assistant director of the chemistry division.

He received a B.S. degree from the City College of New York, and a Ph.D. from New York

University. He has been a lecturer for many years in the Graduate School of Rensselaer Polytechnic Institute, where he is now an adjunct professor.

A past chairman of the Eastern New York section of the American Chemical Society, Dr. Surrey is author of the book, "Name Reactions in Organic Chemistry." He is the author or co-author of over 50 scientific papers and holds about the same number of patents. He is a Fellow of the New York Academy of Sciences and is a member of the American Chemical Society and Sigma Xi, honorary science society.

LEUKEMIA RESEARCH

With the growing certainty that viruses are implicated in leukemia and possibly other forms of cancer, one of the biggest virus hunts in history, combining government and drug industry forces, is now getting under way at the John L. Smith Memorial for Cancer Research in Maywood, N.J. The laboratories are operated by Chas. Pfizer & Co., Inc. in collaboration with the National Cancer Institute, (NCI), of the Public Health Service, Department of Health, Education, and Welfare.

Two electron microscopes are now in operation at Pfizer's Maywood laboratories, with two more shortly to be installed. Microscopists will work in shifts so as to handle thousands of specimens of human cells collected at NCI and other institutions, plus additional field specimens taken in "cluster" areas of leukemia cases. These are compared with specimens from normal and other-disease control areas. With all four microscopes in action, it is believed the laboratories, under the stepped-up program, will be able to process hundreds more of speci-

mens a months than was previously possible.

With animal work pointing to the possibility of isolating a human leukemia virus, pilot studies for developing a technology for mass production of leukemia viruses in tissue culture, sponsored by NCI, is now being carried out at Pfizer under the supervision of John L. Davenport, director of the laboratories. Two different mouse leukemia agents, Moloney and Rauscher viruses are being used. Although they appear similar under the electron microscope, they differ antigenically and biologically and also in the conditions under which they can be grown.

Rauscher and Moloney viruses are being propagated in two ways: (1) in a thymus-spleen tissue culture and (2) from the Plasma of infected mice.

Work is also proceeding on developing experimental vaccines some of which have protected mice against leukemia. Such a vaccine, although its parallel with a human vaccine is still far in the future, is an essential first step in the understanding and possible control of one form of cancer.

FAMILY PLANNING

A new Reference and Resource Program established to provide professionals in the family life and family planning field with original aids for use in counselling and education activities has been announced by G. D. Searle & Co., Chi-

cago medical research and prescription drug manufacturing organization.

Searle, innovator of Enovid, the world's first birth control pill, and Enovid-E and Ovulen, newer oral contraceptives, has established the

Editorials *(Concluded)*

program to help meet the steadily growing demand by professional counsellors for authentic information on the use of oral means of contraception in family planning under a physician's direction.

William L. Searle, Vice President, Marketing, of G. D. Searle & Co., said that available reference and resource aids will include printed materials and audio-visual aids designed for use by physicians in counselling situations, paramedical groups, family life educators, marriage counsellors, educators, welfare authorities, public health officials, sociologists and others in related fields.

The advisory council to the Searle Reference and Resource Program includes outstanding representatives from the fields of medicine, marriage counselling, and family life education. Among them are John Rock, M.D., Clinical Pro-

fessor (Emeritus), Harvard Medical School, and Director, Rock Reproductive Clinic, Inc.; Charles E. Flowers, Jr., M.D., Professor of Obstetrics and Gynecology, University of North Carolina School of Medicine; Gordon E. Bivens, Ph.D., Director, Center for Consumer Affairs, University of Wisconsin; Miss Marrietta Henderson, Chairman, Department of Home Economics, Hood College; Mrs. V. W. Jewson, Executive Officer, National Council on Family Relations; Mrs. Freda S. Kehm, Ph.D., Director, Association for Family Living; Wallace Kuralt, Director, Department of Public Welfare, Mecklenburg County, North Carolina; Rev. Donald R. Young, Ed.D., Director of Training in Pastoral Care and Counselling, The Menninger Foundation; and J. William Crosson, M.D., Assistant Medical Director, G. D. Searle & Co.

DRY WINE AND DIABETICS

Diabetics, who may ordinarily be forbidden alcoholic beverages, can safely and even beneficially drink dry table wines, a diabetes research specialist has found.

The happy news for diabetic patients comes from Dr. Laurance W. Kinsell, Director of the Institute for Metabolic Research at Highland-Alameda County Hospital, in Oakland, Calif.

The report was based on a long-term study of patients kept in a research metabolic ward, with every morsel of food and drink measured to a fraction of an ounce, and with constant measurements of the blood.

When dry (low-sugar) table wines were included in the diet, Dr. Kinsell and his associates found there were no significant increases in blood sugar, or in excretion of sugar in the urine.

Equally important, there were no signs of ketosis.

When plain alcohol diluted with water was used instead of wine, they found there was no rise in blood sugar, but there were definite signs of ketosis in most patients.

The difference was attributed to the probable effects of "one or more of the organic constituents present in wine, but not in distilled alcohol."

If either wine or plain alcohol were used in a diet rich in saturated animal fats, the investigators observed a dangerous rise in blood cholesterol. No such rise occurred however, when the alcoholic beverages were used with unsaturated vegetable fats.



The Doctor's Library

BRAY'S CLINICAL LABORATORY METHODS, 6th Ed., John D. Bauer, M.D., Gelson Toro, Ph.D., Phillip C. Ackerman, Ph.D. C. V. Mosby Company, 1962.

The authors have fulfilled their intent and brought this book up to date with new methods and additional illustrative material. The book will be of value to physicians and medical students as a ready reference to clinical pathology and to technologists for standard methodology. The section on urinalysis is extensive and includes methods for paper chromatography to determine specific substances in urine. The standard procedure for determination of Bence Jones protein is included. There are several new methods which have been found valuable and time saving. The illustrative material in hematology is informative. A standard method for preparation of LE cell smears is given. The newer methods of Snapper and the capillary LE cell test are not included. It is difficult for any book to cover such a rapidly changing field as chemistry in only one section. The authors have given the standard chemistry methods. There are several enzyme determinations which are not given in detail in the text that are used in many laboratories. The EDTA method for calcium in some laboratories has been found to be unsatisfactory because of interference with magnesium. The section on toxicology is very informative and will be of great help to the laboratory which does only the occasional determination in this field. The authors have included numerous references in all of the sections and the appendix includes those formulae which are often required by the clinical chemist but seldom at hand.

W. J. Frable

CECIL-LOEB TEXTBOOK OF MEDICINE, ed. 11. Edited by Paul B. Beeson, M.D., and Walsh McDermott, M.D., Saunders, Phila. 1963. 1,835 pages.

This always trustworthy text has new editors for the 11th edition, as Drs. Cecil and Loeb have retired. But the Cecil formula of being "ever contemporary" has been carried out. The vast amount of new knowledge on viral diseases, genetic disorders, the immune mechanisms are but a few of the 80 new subjects discussed. Even such newcomers as kuru and maple sirip urine are covered. As those who are familiar with the book know, there are numerous contributors, each an

expert in his field. The references at the end of each chapter are valuable for those who want to delve deeper into the different diseases. No physician or medical student will regret buying this volume.

T. R. Van Dellen, M.D.

Maxillofacial Prosthetics: Its Origin and Present Status Arthur H. Bulbulian, D.D.S. Mayo Clinic Proceedings January 1964 (pgs. 3-17).

Relationship of Surgery to Prosthetic Reconstruction of Maxillofacial Areas. James K. Masson, M.D., Mayo Clinic Proceedings January 1964 (pgs. 20-22).

Ambroise Pare, the famous 16th century surgeon, aware of the difficulties confronting surgeons when reconstruction was necessary made important contributions to this science. He suggested a nose that was made of silver or some other durable material. This prosthesis would then be attached to the face by means of strings. The idea somewhat resembled the masks worn at Halloween.

Many materials have since been used for this type of reconstruction. At one time porcelain, vulcanite, celluloid, aluminum, and silver were used. Celluloid was not the best choice since it was easily broken and if the wearer happened to be a smoker, constituted a fire hazard. The drawback to silver and aluminum was the fact that both of these materials are difficult to work with.

The art of maxillofacial reconstruction has come a long way since then. The usefulness of reconstruction has been greatly extended with the improvements of technique accomplished in this field.

Reconstruction by means of prosthetics has many attractive features. They are less expensive than surgical reconstructions, require less time away from home and business, hasten rehabilitation time, involve less expense (an important consideration in elderly persons with limited funds), involve less risk and are a psychological boon to the patient.

Disadvantages to this procedure are few. They must be removed each day and because of exposure change color, usually darken, and must be replaced.

The new materials like polyvinyl chloride compounds

(Continued on next page)

BOOK REVIEWS (Continued)

and silicone rubbers have excellent molding qualities, are lifelike and make detection by the casual observer difficult. They react to color techniques well.

When used with proper surgical planning and good judgment, restoration of maxillofacial is successful.

In the final analysis, whether it is a surgical reconstruction or one done with prosthesis, the end result must meet with the satisfaction of the person. Some feel a flesh and blood reconstruction, even with imperfections, is more desirable.

CANCER OF THE STOMACH. William H. ReMine, James T. Priestley, Joseph Berkson and members of the Staff of the Mayo Clinic. 255 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1964.

This book, written by various members of the Staff of the Mayo Clinic in cooperation with Doctors ReMine, Priestley and Berkson, presents in a coordinate from their findings on the challenging problem of gastric carcinoma and its treatment. The 255 page volume contains an easily readable discussion of the problems, diagnosis, treatment and prognosis for this disease entity. The illustrative material is of high quality and demonstrates in a clear manner the problems being discussed. Considerable attention is given to the various diagnostic procedures used in detecting early lesions such as roentgenological and gastroscopic diagnosis and special laboratory procedures. Techniques involved in the surgical management of carcinoma of the stomach are illustrated by excellent color and black and white drawings. This book with its chapter bibliographies is an excellent reference tool. The Mayo Clinic Staff has presented the data in a coordinated way and has contributed significantly to the understanding of the problem of gastric carcinoma and its treatment.

Harold L. Method, M.D.

CHRISTOPHER'S TEXTBOOK OF SURGERY. Edited by Loyal Davis, M.D. Eighth Edition. 1481 pages, 1341 illustrations on 744 figures. Philadelphia and London: W. B. Saunders Company, 1964.

This eighth edition of **CHRISTOPHER'S TEXTBOOK OF SURGERY**, published only four years after the seventh edition, is fully justified because the rapidly occurring advances in the biomedical sciences has made this revision necessary to reflect the current concepts in the field of surgery. The extent of change in this edition is considerable with addition of new contributors on subjects which are fundamental in any textbook of surgery. A new chapter, *Horizons in Surgery*, demonstrates to students that surgery is the dynamic living and growing art of application of basic science to the treatment of the sick. The list of contributing authors and consultants is outstanding, all having demonstrated their superior knowledge and contributions in their special fields of interest in surgery. As in previous editions the aim is to present surgery with emphasis on the basic principles upon which the education of a sur-

geon must rest. The organization of the subject matter is excellent with avoidance of overlapping and duplication—a fact not normally common in most multi-authored texts. The presentation of the various subjects is unified and the space allotted for each is commensurate with its importance. Excellent reading references to each chapter provide the reader with background material on the disease processes presented. The illustrative material, both photographs and drawings, is of high caliber, showing clearly the problems being discussed. Basic themes have been emphasized in every area of surgery making it not only an excellent preparation for medical students but an important reference to the graduate students of surgery.

Harold L. Method, M.D.

MODERN TREATMENT. TREATMENT OF THE ANEMIAS AND TREATMENT OF CARDIAC ARRHYTHMIAS. Vol. 1, No. 3 (May) 1964. Published bimonthly. Pages 531-789. Harper & Row, New York. \$16.00 per year.

Doctor Edwin D. Bayrd, guest editor in the first half of this review, has selected a widely diversified number of hematologic topics commonly seen by general practitioners and internists in their practice. They will find this an excellent source of information relative to these problems. The other contributors have treated their subjects ably and the material is well presented. These subjects include normocytic, hemolytic, iron deficiency and megaloblastic anemias. Treatment of these conditions is outlined and includes presently accepted forms of therapy.

Doctors J. Willis Hurst and Robert C. Schlant devote the second half of this volume to various cardiac arrhythmia. Included is an excellent review of the physiological mechanisms and causes that produce the arrhythmias. Mode of treatment is outlined and follows the discussion. The more common atrial arrhythmias, as well as the ventricular arrhythmias, have been adequately discussed by the other contributors. Cardiac resuscitation is concisely and expertly discussed. This volume is a handy reference guide and is recommended to be part of the doctor's personal library.

Maurice Gore, M.D.

MODERN TREATMENT. TREATMENT OF INFECTIOUS DISEASES. Vol. 1, No. 4 (July) 1964. Published bimonthly. Pages 795-1033. Harper & Row, New York. \$16.00 per year.

This is a very good review of infectious diseases. It discusses the principles of antimicrobial therapy, the new penicillins, and treatment of major illnesses caused by specific infections. For example, there are chapters on the treatment of infections caused by Beta hemolytic streptococci and staphylococcal infections, treatment of meningitis, urinary tract infections and bacterial endocarditis. This data is of inestimable value to busy practitioners who desire a quick, easily-available source for immediate reference. I recommend this volume to my colleagues who require such information in their daily practice.

Maurice Gore, M.D.

PREVENTIVE MEDICINE, VOLUME VII: Communicable Diseases, Arthropodborne Diseases Other Than Malaria. 370 pages, 65 illustrations, 48 tables, 21 charts, 12 maps, and a comprehensive index. Available for purchase at the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. \$4.25.

As with the preceding volumes in the Army medical history series, this book was written by outstanding authorities in the field of preventive medicine, under the guidance of an Advisory Editorial Board headed by Stanhope Bayne-Jones, M.D.

The many problems which were encountered, and the failures and success experienced during the war in the prevention and control of such diseases as encephalitis, bartonellosis, dengue, filariasis, leishmaniasis, plague, relapsing fever, sandfly fever, typhus fever, scrub typhus, Rocky Mountain spotted fever, and yellow fever are carefully recorded in this volume.

Arnold Lorentz Ahnfeldt

REHABILITATION: A Manual For The Care Of The Disabled And Elderly, by Gerald A. Hirshberg; Leon Lewis; and Dorothy Thomas. J. B. Lippincott Company, Philadelphia, 1964.

The authors have written this book as A Manual For The Care Of The Disabled and Elderly. They have stressed that rehabilitation by necessity must be a multidisciplinary endeavor and discuss the role of the physicians, nurses, therapists, social workers, orthotists, prosthetists, teachers, engineers, and administrators, since all of these professions are involved to some extent

in the total program of medical rehabilitation.

Most of this book deals with specific disabilities, such as neurologic (paraplegia, quadriplegia, etc.), musculoskeletal (arthritis, fractures, amputations, etc.), and cardiorespiratory impairment. Chapters deal with not only types of disability, but also environmental considerations, nutrition and elimination, psychosocial aspects, training and self-care activities, mobility, communication, etc.

The authors state that they have made no attempt to present the various rehabilitation procedures that are used in different treatment centers, but have limited themselves to methods that they have tested and proven to be effective, practical and economical. They have drawn upon their rich experience in total rehabilitation.

The importance of communication and close integration of the efforts of all professional personnel concerned with the care of the disabled is discussed and stressed.

Reference Materials on Medical Rehabilitation, including Self-Care, Psychosocial Aspects of Rehabilitation and Journals And Resources Of Interest For Patients are listed. This book is well organized and contains many fine photographs and illustrations depicting equipment as well as techniques and procedures in rehabilitation. The necessity of continuity of effort by all those working with the disabled patient is stressed.

Physicians, and all other professional personnel such as therapists, nurses, social workers, prosthetists, administrators, and others concerned with the care of the disabled and elderly will find this an excellent text and guide for a total rehabilitation program.

Louis B. Newman, M.D.

"PERMANENT IMPAIRMENT" GUIDES AVAILABLE

The American Medical Association announces the availability of the sixth and seventh guides in the series of "Guides to the Evaluation of Permanent Impairment" developed by the Committee on Rating of Mental and Physical Impairment. They are entitled: "Guides to the Evaluation of Permanent Impairment—The Digestive System" and "Guides to the Evaluation of Permanent Impairment—The Peripheral Spinal Nerves."

These guides, like all the others in the series, have been designed primarily for use by physicians. The guides are, however, of interest and use to all concerned with the medical, administrative, or judicial aspects of programs for the disabled. The previously published guides in the series deal with the extremities and back; the visual system; the cardiovascular system; ear, nose, throat, and related structures; and

the central nervous system.

A limited number of copies of these guides may be obtained, without charge, upon written request to the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn Street, Chicago Illinois 60610.

Much of the issue is devoted to digests of scientific reports made at the Fifth Congress of the International Diabetes Federation at Toronto. These concentrate on two aspects: Who are the diabetics and where may they be found?

An analysis by the newsletter of U.S.P.H.S. statistics indicates that the incidence of diabetes in the U.S. has more than doubled since 1950 and that there may be as many as 6 million cases by 1969. The rising rate is attributed to increasing numbers of older people and overweights in the population, broader diagnostic concepts, and more sensitive screening tests.



Rx Reviews

and New Products

New Anabolic Steroid

An anabolic steroid is responsible for aiding bone growth and helping put weight on children with cystic fibrosis, without producing serious masculinization in either sex.

It also improved the children's muscle tone, eliminated their "pot" bellies and "clubbed" fingers, and ended the cyanosis that some had, the annual meeting of the American Medical Association was told in San Francisco June 22 by Dr. James L. Dennis, professor of pediatrics at the University of Arkansas Medical College. Dr. Dennis reported on a controlled study made in collaboration with Dr. Theo C. Panos at the University's Cystic Fibrosis Clinic.

Masculinizing effects from steroid hormones, such as testosterone, have been an important hindrance in treating such children. This has been an especially strong deterrent in treating girls. However, physicians hesitate to treat boys or girls for more than 6-12 week periods with standard steroid hormones. Winstrol, on the other hand, was given for as long as 18 months in Dr. Dennis' study.

Reporting on a controlled study of 23 children with cystic fibrosis, Dr. Dennis said the anabolic steroid stanazolol (Winstrol) made a significant difference in the bone development, height and weight of a series of 17 boys and girls. They were compared for approximately one year by means of bone x-rays and other methods, with six children who were not given the drug. The 23 children had an average age of about five and one-half years.

The weight increases of those given Winstrol was more than 7 pounds, compared with 1.7 pounds for the untreated youngsters. For the former, this increase for their age was equivalent to a 17-month gain.

X-ray checks disclosed that Winstrol was responsible for average bone maturation corresponding to 16 months. A 7.2 month growth

gain was recorded by the control group.

"On the surface," Dr. Dennis said, "a bone-age increase of 16 months during a 12-month period might seem undersirable, but in these cystic fibrosis patients the initial bone-age retardation was so great that in spite of the 16 months increment during treatment the average bone age was still retarded by 16.7 months at the end of the treatment period."

The hormone produced about the same amount of growth and weight gain in boys as in girls, it was noted.

Even more impressive than growth data were observable body changes.

"Flabby abdominal musculature is characteristic of children with cystic fibrosis," Dr. Dennis said.

"Marked increase in muscle tone became obvious after therapy and was manifest by disappearance of the 'pot' belly.

"An unexplained phenomenon was the almost total regression of 'clubbing' and cyanosis of the fingers in severely affected children."

Regarding masculinizing effects, Dr. Dennis reported that "no patient developed any pubic hair and in none were there observable changes of voice." The absence of pubic hair growth was said to be "in contrast with past personal experiences using other anabolic agents for periods of more than three months, in which as many as 50 per cent developed pubic hair."

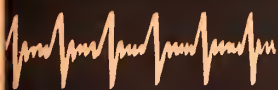
One virilizing sign observed was enlargement of the penis in boys and the clitoris in girls.

"The enlargement promptly regressed on withdrawal of Winstrol," Dr. Dennis said.

NegGram Cited

Good results have been obtained with NegGram, a new antibacterial agent, in treating persistent and recurrent urinary tract infections, especially those caused by *proteus* organisms,

(Continued on page 91)



ISMS Members Win Praise for Contribution to Progress of Medicine Through AMA-ERF

High praise was accorded the more than 10,500 physicians of Illinois for this year's ISMS contribution of \$187,500 to the Education and Research Foundation of the American Medical Association.

The monies—designated for the AMA-ERF Funds for Medical Schools Program—will be distributed to medical schools and research centers across the nation.

Physicians of the Illinois State Medical Society have supported the Foundation program with annual contributions totalling more than \$2,000,000 over the past 10 years, according to Dr. Edward A. Piszczek, president.

A letter directed to him by Lyman J. Smith, AMA-ERF director of programs, said, in part:

"The Board of Trustees of the AMA-ERF has asked me to convey their special appreciation to the physicians of Illinois for your \$187,000 gift in support of the Foundation's Funds for Medical Schools Program.

"We feel we can also express the thanks of the deans and students who are the direct beneficiaries of your generosity.

"Your members can feel extremely proud of their contribution to the future of the profession."



Dr. Edward A. Piszczek, right, ISMS president, presents a check for \$187,500 to Dr. R. M. McKeown, president of the AMA-ERF board of directors, as the Illinois contribution to the Funds for Medical Schools program. Contributions from ISMS physicians to AMA-ERF have totaled more than \$2,000,000 over the past 10 years. This year's presentation was made at the recent AMA clinical meeting in Miami Beach.

Welfare Council Appoints Dr. Piszczek Chairman of Suburban Health Services

Dr. Edward A. Piszczek, ISMS president, has been appointed chairman of the Committee on Suburban Health Services of the Welfare Council of Metropolitan Chicago.

Urge ISMS Physicians Distribute Poison First Aid Chart to Patients

"First Aid for Accidental Poisoning"—a new chart designed for home use by the Illinois Department of Public Health—is recommended by the ISMS Public Safety Committee to all physicians for enclosure in statements to their patients, announced Dr. Julius M. Kowalski, chairman.

The small chart can be obtained in large numbers, free of charge, by writing to the department's

Bureau of Hazardous Substances and Poison Control in Springfield.

The chart, printed on lightweight paper and of a size that will fit in a standard envelope, presents vital first aid information on swallowed poison, treatment of shock, poison in the air, poison in the eye, poison on skin, poison bites, what to do "before your physician comes" and safeguards "to prevent poisoning."

COUNTY CAPSULES



CHRISTIAN Medical Society has become a member of the Oak Park-River Forest Chamber of Commerce.



MACOUPIN COUNTY Medical Society at a recent dinner meeting paid tribute to Dr. E. R. Chamness on becoming a member of the Fifty Year Club for his service of a half century in medical practice.



MCLEAN COUNTY Medical Society President Dr. G. B. McNeely has been appointed a diplomate in preventive medicine to the Pan American Medical Association.



MORGAN COUNTY Medical Society's Dr. Henry D. Staras has been appointed as superintendent of the Peoria State Hospital, it was announced by Dr. Harold M. Visotsky, director of the Illinois Department of Mental Health.



WINNEBAGO COUNTY Medical Society's Dr. Vernon C. Voltz, a Rockford ophthalmologist, was the first physician from that area chosen to serve on the S.S. Hope hospital ship in French Guiana.

Billboards Throughout Illinois Promote Checkups as 'Best Cancer Protection'



The ISMS preventive medicine billboard campaign resumed in January with the support of the Illinois Division of the American Cancer Society. Pictured above is the poster that is being seen on more than 150 billboards throughout the state by thousands of Illinois residents. Since it was proposed that in cancer—more than any other disease—medical science helps those who help themselves, the poster was designed to portray the physician as "Your Best Cancer Protection." The implied emphasis, therefore, is on periodic medical examination. It is hoped that the billboards and exposure of the supportive educational materials for newspapers, radio and television will motivate the public toward this end, said Dr. Leo P. A. Sweeney, chairman of the ISMS Public Relations Committee.

Elect Dr. Maynard Shapiro President of Health Careers Council of Illinois

Dr. Maynard Shapiro of Chicago, ISMS representative to the Health Careers Council of Illinois, has been elected president of that organization for 1964-65 at its first annual meeting.

The Council is composed of representatives of professional societies in the health field, as well as delegates from various public interests. Organized in 1963, it is dedicated to increasing the supply of educated, well trained health personnel.

Dr. Shapiro said that during the first year of its existence as an independent organization, the Health Careers Council of Illinois prepared and distributed information on careers in the health field to public and private schools, parents and students.

In addition, said Dr. Shapiro, the Council participated in a number of career counseling programs throughout the state.

Maxine Miller, director of the Careers in Social Work Department of the Chicago Welfare Council, and Dorothy Hruby of



DR. MAYNARD SHAPIRO

the Department of Occupational Therapy at the University of Illinois were elected vice president and treasurer, respectively.

9 County Societies Announce New Officers

A number of county medical societies have elected new officers for the coming year.

Voted president of the Crawford County Medical Society at its 84th annual meeting was Dr. Don Knapp. On the slate with him are Dr. Charles N. Salesman, vice-president, and Dr. John W. Long, who begins his 45th year as secretary-treasurer. Drs. Salesman and R. B. Murphy will serve as delegate and alternate, respectively, to ISMS.

Other physicians elected to office in county medical societies include:

Kankakee County Medical Society: Louis Ehrlich, president; A. A. Palow, vice-president; H. P. Swartz, secretary-treasurer; and Donald A. Meier and Dale M. Learned, delegates.

Macon County Medical Society: Carl L. Sandburg, president-elect; Clarence G. Glenn, president; William T. Couter, secretary; Charles O. Stanley, treasurer; Maurice

Murfin, delegate; and H. J. Burstein, alternate.

Madison County Medical Society: W. W. Bowers, president; Abrom Grandia, president-elect; Leo Green, secretary; and Henry Malench, treasurer.

McLean County Medical Society: George O'Neil, president; George France, vice-president; Preston Houk, secretary-treasurer; L. T. Fruin, delegate; and A. E. Livingston, alternate.

Pick Experts to Judge 1st ISMS Journalism Awards Program for '64

Entries to the ISMS 1964 Journalism Awards Program—designed to acknowledge newspaper, radio and television contributions to a better public understanding of medicine and health in Illinois—will be judged by a prominent cadre of media experts, it was announced by Dr. Leo P. A. Sweeney, chairman of the ISMS Public Relations Committee.

Judging the television entries will be Bill Irvin, TV columnist for Chicago's American, and James Green, midwest regional manager of TV Guide.

Judges for the radio and newspaper entries are being provided under the auspices of the Publicity Club of Chicago. They include: Merril R. Swartz of Griswold-Eshleman Co., chairman of the panel; Ralph Liguori, publicity director of Curtis Circulation Co.; Mrs. Dene R. Murray of the National 4H Service Committee; and Brace Pattou, vice-president of Charles Feldstein Co.

Dr. Conley Elected to Head General Practice Academy

Dr. Thomas J. Conley of Park Ridge has been named president-elect of the Illinois Academy of General Practice. Formerly president of the medical staff at Resurrection Hospital, he serves on the Chicago Medical Society's Liaison Committee to Chicago Medical Schools and its Advisory Committee to Public Health Agencies.

Peoria Medical Society: Fred Z. White, president; Clinton S. M. Koerner, president-elect; Robert S. Easton, secretary; H. Sargent Howard, treasurer; Fred Long and Irving L. Turow, board members; Norman Powers, delegate; and S. M. Scalzo, alternate.

Tazewell County Medical Society: Joseph Aronoff, president; Harry Shepard, secretary-treasurer.

Vermilion County Medical Society: Stanley Levin, president; L. W. Tanner, secretary-treasurer; Erle McDonnell, vice-president; Grover Seitzinger, delegate; and Edward Andracki, alternate.

Wayne County Medical Society: E. S. Talaga, president; A. R. Marks, vice-president; Sigmund W. Konarski, secretary-treasurer; and C. J. Jannings, delegate.

IMPAC Gets AMPAC's Thanks for Aid in 1964



Dr. V. P. Siegel beams his appreciation as he displays the AMPAC award to the Illinois Medical Political Action Committee. Presented at a Miami Beach conclave, the citation commended IMPAC as one of the 10 state groups which made the highest total contribution to the American Medical Political Action Committee. Dr. Siegel is a member of the IMPAC Council and chairman of the Illinois State Medical Society's Committee on Legislative Affairs.

Hospital Assn. Seeks Legislation to Halt Mail Order Nursing Schools

The Illinois Hospital Association has launched a major effort to secure passage of laws to prevent unnecessary hospital construction, to eliminate mail order schools of nursing and to keep racketeers from owning hospitals.

Bills slated for introduction in the state legislature this month would:

Require licensing for practical nurses and would require correspondence schools for nurses to be approved by the state boards of nursing.

Remove the three-year requirement for regular approved nursing programs that could be taught in hospitals and in junior and community colleges.

Empower the state health department to prevent construction of a new hospital if the sponsors cannot document need for additional hospital services in the area, or if there is a serious question about the sponsor's "qualification, background and character."

Form Morgan County Auxiliary

The Morgan County Medical Society now has an official distaff side with the formation of the first woman's auxiliary in its history.

Headed by Mrs. Stuart P. Lipert of Jacksonville, as president, the inaugural slate of officers includes Mrs. Thomas L. Wilson, vice president, and Mrs. Robert Hartman, secretary-treasurer, both of Jacksonville.

Making its debut at the recent District Six meeting, the Morgan auxiliary was presented a certificate commemorating its founding.

Present for the installation, representing the ISMS Auxiliary, were Mesdames Willard Scrivner, president; Mary Koenig, Eunice Roller, and Vi Shulman.

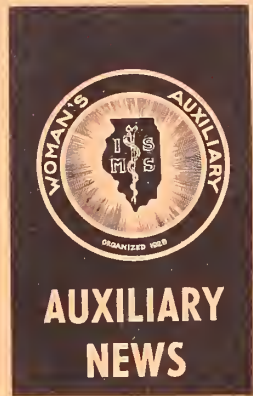
Election results of other county medical society auxiliaries also

have been announced.

Winnebago Auxiliary: Mesdames R. Glenn Smith, president; LeBaron Paul Johnson, vice president; Miles Gulickson, recording secretary; Robert Lewis, corresponding secretary; and Ray Beers, treasurer.

Chicago West Side Auxiliary: Mesdames Michael Serio, Sr., president; Adolph Kraft, vice president; F. A. Cirrincione, recording secretary; Alfred Pagano, counselor; and Eugene T. McCenry, alternate counselor.

Chicago North Shore Auxiliary: Mesdames O. Theodore Roberg, Jr., president; Fernly E. Johnson, president-elect; Gordon L. Rosene, vice-president; Emanuel S. Anawis, treasurer; Lorin M. Olson, counselor, and Joseph R. DeCaro, alternate counselor.



EDITOR

Mrs. Oliver Veneklasen

ASS'T EDITOR

Mrs. Theodore Proud

Benevolence Fund Needs Auxiliary Aid to Meet Rising Demand

The Benevolence Fund was established by the Illinois State Medical Society for the assistance or relief of needy members of the Society, their widows, or their minor children. As an auxiliary to the state medical society, we are contributors to this fund.

Originally a sum was set aside and the earnings of it used for benevolence purposes. Requests, however, have multiplied to such an extent that the sum must be increased in order to keep the principal intact.

The Woman's Auxiliary sets aside one dollar from each member's dues for the Benevolence Fund. In addition to this amount, there are contributions and memorial gifts which are most gratefully accepted. To establish a memorial, send your check thru your county benevolence chairman to the state chairman, giving the name and address of the donor, the name of the person to be honored and the name and address of the person to be notified of the gift. Cards of acknowledgment are then sent to all concerned.

Part of the proceeds from Cook County's annual ways and means party is assigned to the Benevolence Fund. Since members from many other counties attend this conference, the ways and means party is literally a statewide project.

MRS. SAMUEL PLICE
State Benevolence chairman

Vermilion Medical Auxiliary Educates Gun Enthusiasts on Firearm Safety

The Auxiliary to the Vermilion County Medical Society drew banner headlines from the Danville press recently for a firearm safety course it sponsored especially for teenage boys.

As it turned out, however, the boys' attendance was equaled, if not surpassed, by interested mothers and sisters. The auxiliary presented the program as a public service aimed at preventing the rash of tragic gun accidents in the home and in the field.

According to course lecturer M-Sgt. Wayne Loudy of Chanute Air Force Base, 99 per cent of fatal gun accidents are the result of "pure carelessness and ignorance."

The Vermilion auxiliary urges young gun enthusiasts and their parents to observe the following safety rules:

1. Always handle a gun as if it is loaded.
2. Don't point the muzzle at anyone.
3. Use the safety catch, but don't depend on it. "It's notorious

for being faulty."

4. Check the chamber to be sure it doesn't contain a shell.

5. Store the gun and ammunition separately.

6. Keep the gun unloaded and locked up out of children's reach.

Motto for '65

Health and Freedom through Love and Service with Emphasis on Membership, Legislation and Community Service.

Rx Reviews (cont'd from page 86)

according to a report in the *New Zealand Medical Journal* (63:498, 1964).

The drug was effective in nine out of ten patients with infections caused solely by *proteus*, Drs. J. T. Holland and J. Z. Montgomerie state. When tested against discs, all 118 *proteus* organisms cultured from patients' urine were sensitive to NegGram (nalidixic acid.)

The drug, which is taken orally, was given to 40 patients in Auckland Hospital. All had previously been unsuccessfully treated with other drugs or had recurrent infections of the urinary tract.

In addition to NegGram's effectiveness against *proteus*, good results were also obtained in infections caused by *E. coli*. Where it was the only organism involved, 10 out of 18 patients responded to the drug. A good response, according to the authors, consisted of having sterile urine two weeks after therapy was initiated. Such patients are referred to as being immediate cures. Among the infections treated were chronic pyelonephritis, renal calculi, urethritis, paraplegia and prostatic hypertrophy.

The investigators report that side effects were minimal, and no serious reactions were observed.

NegGram is manufactured by Winthrop Laboratories.

Hangover Clinic

The Physician's Wine Appreciation Society of New York, composed of more than 200 doctors who enjoy good food and drink, conducted a "Hangover Clinic" New Year's Day in the Longchamps Restaurant (at Madison Avenue and 49th Street) for members who may have celebrated too earnestly New Year's Eve.

From the hours of 1 p.m. to 4 p.m. the doctors served French 75's—made with three ounces of French Champagne and one ounce of Cognac—to the members of their society.

Said Dr. Herbert Gould of White Plains, New York, president of the society: "Champagne and Cognac, when mixed together, are known throughout the civilized world for their effect in helping restore energy and vigor and in combatting indications of melancholy and

depression. Just the thing for New Year's Day!"

Also available at the Longchamps Hangover Clinic: packets of aspirin.

Drainage Bag

A completely new concept in urinary drainage equipment designed for one patient use has been announced by LARJAN Products.

The new LARJAN Drainage Bag is a 'closed system' type fabricated entirely from highest quality plastics, in one design, to fit *any* hospital bed. The drainage bag is said to answer the needs of either the bedridden or ambulatory patient without modification. The LARJAN Drainage Bag can be removed, flushed and returned to proper position on the bed without disturbing the hanger.

The LARJAN Drainage Bag has a rigid plastic header which incorporates an integral handle. The handle will not separate from the bag. The inlet tube of the drainage bag is furnished with a one-way valve to assure 'closed system' urine collection. A smooth-fitting pour spout is provided for convenient decanting and a hard plastic spout cover prevents the escape of urine odor.

Sixty inches of surgical quality clear plastic tubing is included with a Shur-Grip Connector and protective cover at the catheter tube end. A U-Stop Clamp is furnished to prevent urine seepage when the drainage bag is removed for draining and flushing. The drainage tubing is packaged on a plastic reel to prevent kinking. The reel is discarded when the unit is connected.

A unique feature is the mounting strap of high-strength filament adhesive with a nylon buckle-and-snap device that flips on and off the drainage bag handle. The strap may be loop-mounted over the bedrail or applied simply by firm finger pressure to the required position on the bed frame.

LARJAN Drainage Bag units are sterile-packaged in individual plastic envelopes. The sterile unit is ready for use at the bedside without additional preparation. Complete catalog

(Continued on next page)

Rx Reviews (cont'd)

data and pricing information is available by writing to the manufacturer: LARJAN Products, 534 Center Street, Braddock, Pennsylvania, 15102.

Darkfield Condenser

It is well known that the fluorescent antigen-antibody technique demands extraordinary high light intensity. A new Reichert immersion cardioid condenser yields the highest possible brightness and produces most brilliant darkfield images.

The cone-shaped light bundle emitted by the condenser has a numerical aperture ranging between 1.18 to 1.42. This enlarged range of this illuminating aperture results not only in increased image brightness, but also enables the identification of additional specimen details. Even under binocular observation and

when using the multilens plane achromatic objective 100/1.25 with iris and 10x eyepieces, the new condenser renders completely adequate image brightness. As a result of the increased light transmission, exposure periods in photomicrography can be reduced substantially—a very significant factor for the F.A. technique.

For ideal darkfield illumination, an adequate quantity of immersion oil must be applied to the front lens (light exit) of the condenser. The diameter of the condenser front lens was reduced to minimize the adhesive action of the immersion oil on the object slide, eliminating the disturbance of the specimen while adjusting the condenser. To prevent the overflow of immersion oil, the new condenser is equipped with a circular groove. A bubble-free immersion contact between the condenser front lens and the bottom of the object slide must be accomplished by vertical adjustment of the

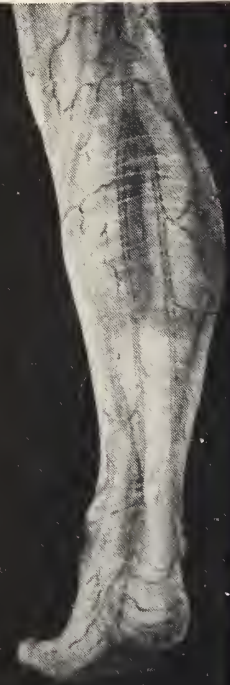
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IN PERIPHERAL VASCULAR DISEASES

where ischemia causes muscle distress—pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceration of extremities.

condenser. The quantity of immersion oil applied upon the condenser front lens must be sufficient to adequately cover the entire upper circular surface of the condenser so that the immersion remains intact throughout the investigation.

For ideal darkfield illumination, the specimen must be embedded in a media of sufficiently high refractive index between the object slide and the coverglass. The condenser is designed for use with object slides of up to 1.3 mm. thickness. Every darkfield condenser must be precisely centered to the objective. To achieve perfect alignment, the new Reichert condenser can be supplied with a built-in centering device for use with microscope without a centerable condenser carrier (substage). For microscopes with a centerable condenser carrier (substage), the condenser is furnished without a centering device. To ease the alignment of the condenser to an objective of high magnification, a circle is etched into the center of the light exit of the condenser to permit precentration with an ob-

jective of low magnification.

To achieve optimum contrast, 100x oil immersion objective should be equipped with an iris diaphragm.

To obtain the highest possible light intensity, objectives of the highest numerical aperture should be used for the F.A. Technique. On the basis of practical experience the following objectives are particularly recommended for critical antibody fluorescence investigations.

Reichert Plane Achromat

oil 100/1.25/160 w/iris

Reichert Plane Achromat

dry 63/0.90/160 w/corr. collar

Reichert Fluorite

dry 63/0.85/160 w/corr. collar

Reichert Fluorite

dry 40/0.75/160 (in preparation)

Please contact us for further particulars about this new Darkfield Condenser and the Reichert microscopes for fluorescence microscopy. Write to: William J. Hacker & Co., Inc., P.O. Box 646, West Caldwell, New Jersey 07007.



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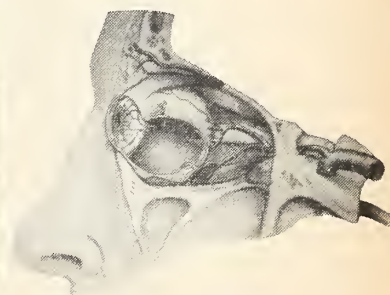
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pulse rate or blood pressure
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blood flow in ischemic tissues
• essentially safe, well
tolerated, with rapid and
sustained response • economical

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palpitation. precautions: Use with
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paroxysmal tachycardia, severe
angina pectoris and thyrotoxicosis.
contraindication: Acute
myocardial infarction.

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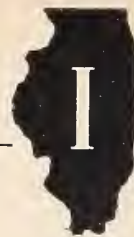


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Appointments

Dr. William A. Cooper, associate director of medical research, Winthrop Laboratories, has been appointed to the additional position of director of medical relations for the West Coast, it was announced by Dr. Theodore G. Klumpp, president.

In his new capacity, Dr. Cooper will supervise in the western states the company's research program involving both new and established drugs. His headquarters will be: Winthrop Laboratories, Scott Drive, Menlo Park, California.

Dr. Cooper also serves as associate professor of clinical surgery, Cornell University Medical College, and associate attending surgeon, New York Hospital. He is a diplomate of the American Board of Surgeons, a Fellow of the American College of Surgeons, and a member of the New York Surgical Society, Society of University Surgeons, and other professional groups.

Elections

Dr. Francis E. LeJeune, New Orleans, is the new President-Elect of the American Academy of Ophthalmology and Otolaryngology. He will assume the presidency January 1, 1966. Members elected Dr. LeJeune and other officers at the business meeting held during their 69th annual meeting at the Palmer House, October 18 through 23.

Dr. John R. Lindsay of Chicago, President, introduced the President for the year 1965, Dr. Edwin B. Dunphy of Cambridge, Massachusetts. Other members taking office on January 1, 1965 will be First Vice-President, Dr. John J. Conley of New York; Second Vice-President, Dr. A. Gerard De Voe of New York; Third Vice-President, Dr. Frederick R. Guilford of Houston.

Councillor, Dr. A. Edward Maumenee of Baltimore, was elected to a four-year term.

The Secretaries who continue in office are: Dr. Kenneth L. Roper of Chicago, Secretary for Ophthalmology, in charge of planning the scientific program for eye doctors; Dr. Clair M. Kos of Iowa City, Secretary for Otolaryngology; and Dr. A. D. Ruedemann of Detroit, Secretary for Public Relations. Secretary for Instruction in Ophthalmology, Dr. Glen G. Gibson of Philadelphia; Secretary for Instruction in Otolaryngology and Maxillofacial Surgery, Dr. Eugene L. Derlacki of Chicago. Secretary for Home Study is Dr. Dean M. Lierle of Iowa City. Dr. William L. Benedict of Rochester, Minn. is Executive Secretary-Treasurer.

Dr. Michael J. Hogan of San Francisco will retire as senior Councillor. Dr. Francis L. Lederer of Chicago will be senior Councillor for 1965; other Councillors will be Dr. Francis Heed Adler of Philadelphia, Dr. Walter P. Work of Ann Arbor, Michigan, and Dr. A. Maumenee of Baltimore, Maryland.

The American Academy of Facial Plastic and Reconstructive Surgery, Inc., was formed here yesterday through the merger of two national associations of otolaryngologists.

Entering into the merger were The American Otorhinologic Society for Plastic Surgery, Inc., and The American Society of Facial Plastic Surgery, Inc. The membership of both groups approved the move at a meeting in the Palmer House.

The new medical society, expected to include approximately 700 physicians, will consist mainly of otolaryngologists who perform plastic and reconstructive surgery of the head and neck. It was formed with the assistance of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology.

Essay Contests

The Journal of Industrial Medicine and Surgery announces its second annual awards competition of \$1,000 for the most outstanding original manuscript on the subject "The Industrial Health Department: Objectives and Achievements." All manuscripts submitted will become the property of Industrial Medicine and Surgery and will be considered for publication in that journal. For additional information write to Industrial Medicine and Surgery, P.O. Box 306 Tamiami Station, Miami 44, Florida.

The Central Association of Obstetricians and Gynecologists is offering awards totalling \$750.00 for outstanding investigative or clinical work in the field of Obstetrics and Gynecology. Original manuscripts must be submitted in triplicate not later than June 1, 1965, to the Secretary, Thomas W. McElin, M.D., 636 Church Street, Evanston, Illinois 60201. The Annual Prize Award of \$500 and a Certificate of Merit Award of \$250.00 will be presented to two successful authors at the Annual Meeting of the Association October 7-9, 1965, in Cincinnati, Ohio.

Films

A new CPC motion picture, the second of its type designed to permit audience participation and discussion of a special clinical case, is now available on free loan from The Wm. S. Merrell Company, Cincinnati, Ohio.

The new film entitled "Clinico-Pathological Conference at Cook County Hospital" presents an unrehearsed case description and differential diagnosis from this leading medical teaching center.

The film is divided into two parts on a single reel. Between Parts one and two the projector may be stopped while the audience discusses the case and each physician makes his own diagnosis. Part two of the film reveals the tissue findings both gross and microscopic and the final case summary is presented.

The case was selected by the Pathology Department of Cook County Hospital and is presented by Steven O. Schwartz, Director, Department of Hematology, Hektoen Institute for Medical Research and Cook County Hospital.

Dr. Schwartz also is Professor of Medicine, Northwestern University Medical School.

Discussion of the x-ray findings is conducted by Hildegard A. Schorsch, Assistant Roentgenologist, Department of Radiology, Cook County Hospital and the Stritch School of Medicine, Loyola University.

Paul B. Szanto, Director, Department of Pathology, Cook County Hospital and the Hektoen Institute for Medical Research, details the gross and microscopic findings. Dr. Szanto is also Chairman of the Scientific Committee, Hektoen Institute for Medical Research.

"Clinico-Pathological Conference at Cook County Hospital" presents the case of a 25-year-old unemployed painter who complained that about one month prior to admission his eyes began to "turn yellow". He denied loss of appetite and had no chills, fever, weight loss and did not complain of being itchy. His urine was dark at times but he stated there was no blood in the urine or stool. On three previous hospital admissions the patient had been jaundiced; twice before he had been drinking one-half to one pint of whiskey daily and eating irregularly. His abdomen had increased in girth during the last three weeks and he had noticed swelling of the ankles during the last two weeks.

The single reel, 16 mm. color-sound motion picture has a total running time of thirty-eight minutes. Part one (case presentation) has a running time of twenty minutes—part two (pathology and case summation) runs eighteen minutes.

Merrell provides the audience with a printed protocol of the case containing a sealed section which includes pathology and final diagnosis.

Corrective surgery for varicose veins and ulceration is described in detail for medical audiences in a new film made available today through the Wyeth Film Library.

Approved by the Committee on Motion Pictures of the American College of Surgeons, the film was produced this year in Melbourne, Australia, under the direction of Dr. John Mullany of the Bethlehem Hospital there.

The 16-mm, 22-minute sound film explains briefly the causes of varicose veins, illustrates

(Continued on next page)

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NEWS and ANNOUNCEMENTS (Cont'd.)

diagnostic measures, demonstrates corrective surgical techniques, and shows postoperative results.

Suitable for showings to surgeons, surgical residents, interns, and students, the film is available on three weeks' notice through Wyeth representatives or through the Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

The Pharmaceutical Manufacturers Association is offering a catalog describing 169 motion pictures suitable for lay viewing pertaining to the health field. Copies can be secured by writing to the Director of Public Information, Pharmaceutical Manufacturers Association, 1411 K St., N.W., Washington, D.C., 20005.

A 72-page catalog of more than 1,700 free-loan and rental films, available to clubs, churches, industries and other community organizations, has been issued by Association Films, national 16mm film distributor. The catalog, largest in the company's 53 years, offers films on travel, sports, current events, entertainment, safety, religion, history and many other subjects.

Included in the free-film library are such films as: "Unisphere: Biggest World on Earth," "Grouse Hunting with Ted Williams," "The Twentieth Century" (100 episodes from the award-winning TV series), "Jack Twyman in Basketball Fundamentals," "American Miniatures" (a film series on historic sights and famous cities), "The Story of Dr. Lister," "Europe from Dusk to Dawn," and more than 700 others. As a special service, organizations can order full-hour film programs under a plan called "Travelcade/60." Each program is comprised of several sports and travel films.

Copies of "Free Loan Films, Sales and Rental Subjects," may be ordered from Catalog Department, Association Films, Inc., 347 Madison Avenue, New York, N.Y. 10017. The company has five regional film centers in Ridgefield, N. J. (Broad at Elm); La Grange, Ill. (561 Hillgrove Ave.); Hayward, Calif. (25358 Cypress Ave.); Dallas, Texas (1621 Dragon St.) and Oakmont, Pa. (324 Delaware Ave., Allegheny County).

(Continued on page 100)

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Meeting Memos



January 14-16—Symposium on DERMATOLOGY IN GENERAL PRACTICE. Mound Park Hospital Foundation, Department of Medical Education of the Mound Park Hospital, the Florida Institute for Continuing University Studies, Medical and Research Divisions of Bay Pines V. A. Center, Pinellas County Medical Society, American Academy of General Practice—January 14 to 16, 1965, inclusive. The Foundation reserves the right to limit registration. Fee \$40.00. 18 Accredited Hours by the American Academy of General Practice. Address DERMATOLOGY, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida, 33701.

January 20-22—The American Diabetes Association is holding its Twelfth Postgraduate Course, *Diabetes in Review: Clinical Conference, 1965*, January 20, 21 and 22 at The Drake hotel in Chicago, in cooperation with the Diabetes Association of Greater Chicago. The Faculty will be composed of 32 outstanding authorities.

The Committee on Professional Education of the American Diabetes Association, chaired by T. S. Danowski, M.D., of Pittsburgh, Pa., President-Elect of the Association, is responsible for the Postgraduate Course Series. Dr. Danowski is also Director of this year's Course. Arthur R. Colwell, Sr., M.D., and Henry T. Ricketts, M.D., both of Chicago, are Co-Chairmen of the Course and the Local Committee which arranged the program.

Wednesday morning, January 20, will be devoted to four lectures on various aspects of diabetes, metabolism, and endocrine interrelations. All sessions of the Course will end with a Question and Answer Panel except the closing session on Friday afternoon.

The Wednesday afternoon lectures will deal with the latest knowledge of the Islands of Langerhans, and with reviews of current studies on insulin and insulin-like activity.

The Thursday morning session, January 21, will include a talk on "The Pregnant Diabetic and Her Child", featuring the presentation of a patient. Other lectures that morning will deal with prediabetic manifestations, the treatment of emergencies in diabetes, diabetic ketoacidosis, and lactic acidosis.

During Thursday afternoon the Eighth Annual Rollin T. Woodyatt Memorial Lecture of the Diabetes Association of Greater Chicago will be delivered by Arthur R. Colwell, Sr., M.D. It is entitled "Milestones of Progress in Diabetes". Following that, there will be discussions of the effects of drugs on blood glucose, management of the ambulatory patient, and the present status of oral therapy.

A symposium on the disorders of lipid metabolism, and discussions on urinary tract infections and on diabetic neuropathy, will take place on Friday morning, January 22. Friday afternoon will cover various aspects of diabetic vascular disease, endocrine ablation in the management of diabetic retinopathy, and the relation of small blood vessel disease to the treatment of diabetes.

Accreditation: The Course is acceptable for accredited hours by the American Academy of General Practice.

Registration: The three-day Course is open to Doctors of Medicine. The fee is \$40 for members of the American Diabetes Association; \$75 for nonmembers.

Social Activities: All registrants will be guests of the Association at the Banquet on Wednesday evening, January 20, which will be preceded by a Social Hour (by subscription). The Banquet speaker will be Tony Weitzel, well known columnist.

Further Information: A copy of the Program is enclosed. Additional data and registration forms may be secured from the American Diabetes Association, 18 East 48th Street, New York, New York 10017.

February 4-5—A two-day Symposium on Noise in Industry will be offered on February 4 and 5, 1965 in Cincinnati, Ohio. Nationally known speakers will discuss various aspects of this growing industrial health problem. Tuition is \$35 per person which includes two lunches and a dinner. The featured speaker at the dinner meeting will be Dr. Aram Glorig who will discuss "Medico-Legal Aspects of Noise."

For further information, contact Mrs. Adelaide Badgley, Secretary, Institute of Industrial Health, at Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati, Ohio 45219.

March 5-11—The 1965 Loma Linda University School of Medicine Alumni Postgraduate Convention will be in Los Angeles.

Dr. Samuel H. Fritz, general chairman for the event, announced today that leading authorities in more than a dozen medical specialties will report to the convention's scientific assembly at the Ambassador Hotel. The 1965 program will be the thirty-third sponsored by

the alumni association in cooperation with Loma Linda University School of Medicine.

Speaker of the scientific assembly will be Major General Floyd L. Wergeland, a 1932 Loma Linda alumnus who retired earlier this year as chief medical officer for U.S. Armed Forces in Europe. Dr. Wergeland will be assisted by Robert F. Chinnock, M.D., professor of pediatrics at the school.

The postgraduate convention, open to all physicians and medical students in southern California as well as to Loma Linda University graduates from around the world, includes medical refresher courses, scientific exhibits, the scientific assembly program, the annual convention banquet, and weekend religious services.

Dr. Paul B. McCleave, director of the American Medical Association department of medicine and religion, will discuss the importance of religious orientation in the practice of medicine during the convention's opening meeting, Dr. Fritz says.

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Starting Dates — 1965

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 MANAGEMENT OF COMMON FRACTURES & DISLOCATIONS,
 One Week, March 1
 GALLBLADDER SURGERY, Three Days, March 8
 SURGERY OF HERNIA, Three Days, March 11
 PEDIATRIC SURGERY, One Week, March 22
 PROCTOSCOPY & SIGMOIDOSCOPY, One Week, Jan. 18
 VARICOSE VEINS, One Week, January 18
 GYNECOLOGY, Office & Operative, Two Weeks, March 22
 VAGINAL SURGERY, One Week, February 15
 BOARD REVIEW COURSE IN GYN-OB, Two Weeks, March 1
 OBSTETRICS, General & Surgical, Two Weeks, March 8
 PEDIATRIC SURGERY, One Week, March 22
 BOARD REVIEW COURSE IN MEDICINE, Part II, One Week,
 March 15
 BASIC ELECTROCARDIOGRAPHY, One Week, March 1
 PATHOLOGY BOARD REVIEW COURSES FOR SPECIALTIES,
 Request Dates
 ARTERIOGRAPHY, Four Days, February 2
 ANESTHESIA, Inhalation, Endotracheal, Regional, Request
 Dates

*Information concerning numerous other
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NEWS and ANNOUNCEMENTS (Cont'd)

Grants

A total of \$308,412 in grants to support eight research projects has been accepted by the University of Illinois College of Medicine, 1853 West Polk Street, Chicago.

Four of the grants were awarded by the United States Public Health Service. The remaining four grants are from the Department of the Army, Schering Corporation, American Heart Association, and Abbott Laboratories.

Announcement was made last month of a grant of \$178,650 made by the John A. Hartford Foundation, Inc., to the Hospital Research and Educational Trust of the American Hospital Association. The amount is half of the estimated cost of developing and implementing an Approval Program for inpatient care institutions other than hospitals such as nursing homes. Hospitals are already being accredited by the Joint Commission on Hospital Accreditation.

"This phase of the program is to extend over a three-year period and the American Hospital Association will finance the other half of the cost," said Clarence E. Wonnacott, president of the American Hospital Association.

It is estimated that there are some 25,000 nursing homes that operate under different names such as convalescent homes, homes for the aged, etc. The quality of care rendered by these homes varies from very poor to excellent. The general public has no way of knowing which they are selecting.

A new \$5,060,000 six-floor Medical Science Addition to the University of Illinois Research and Educational Hospitals and College of Medicine in Chicago has been completed to provide much-needed clinical, laboratory and office space.

The entrance of the Addition, located on Wolcott Street between Polk and Taylor Streets, will serve as the new entry to various hospital out-patient clinics.

The Orthopedic Clinics have already moved into the main floor area as has the Office of

Research in Medical Education. In the near future, the pediatric clinic, clinical administration, an otolaryngology laboratory and three ophthalmology offices will also move into the first-floor area.

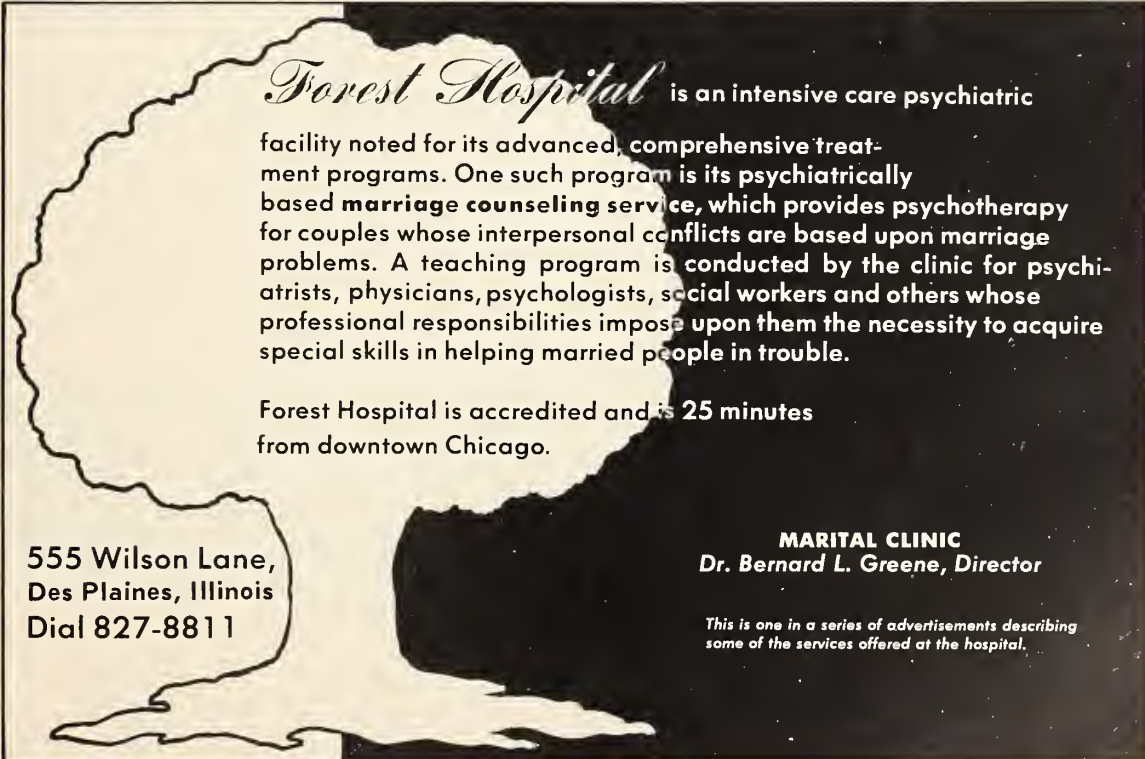
Movement of the University's Aeromedical Laboratory into the basement of the new building is now in progress.

The second floor of the building will be occupied by the Department of Physiology.

February Crippled Clinics are:

- February 3 Rock Island Cerebral Palsy—
Foss Home, 3808 Eighth Avenue
- February 3 Metropolis—Methodist
Educational Building
- February 3 Hinsdale—Hinsdale Sanitarium
- February 5 Chicago Heights Cardiac—
St. James Hospital
- February 9 Peoria General—Children's
Hospital
- February 9 East St. Louis—St. Mary's
Hospital
- February 10 Champaign-Urbana—McKinley
Hospital

- February 11 Anna—Union County Hospital
- February 11 Macomb—McDonough District
Hospital
- February 11 Springfield General—St. John's
Hospital
- February 12 Evanston—St. Francis Hospital
- February 16 Belleville—St. Elizabeth's
Hospital
- February 17 Chicago Heights General—St
James Hospital
- February 18 Litchfield—Madison Park School
- February 18 Rockford—St. Anthony's
Hospital
- February 18 Bloomington (A.M.)—St.
Joseph's Hospital
- February 18 Elmhurst Cardiac—Memorial
Hospital of DuPage Co.
- February 19 Chicago Heights—Cardiac—St.
James Hospital
- February 23 Peoria General—Children's
Hospital
- February 23 Effingham Rheumatic Fever &
Cardiac—St. Anthony Memorial Hospital
- February 24 Springfield Cerebral Palsy
(P.M.)—Memorial Hospital
- February 24 Aurora—Copley Memorial
Hospital



Forest Hospital is an intensive care psychiatric facility noted for its advanced, comprehensive treatment programs. One such program is its psychiatrically based marriage counseling service, which provides psychotherapy for couples whose interpersonal conflicts are based upon marriage problems. A teaching program is conducted by the clinic for psychiatrists, physicians, psychologists, social workers and others whose professional responsibilities impose upon them the necessity to acquire special skills in helping married people in trouble.

Forest Hospital is accredited and is 25 minutes from downtown Chicago.

**555 Wilson Lane,
Des Plaines, Illinois
Dial 827-8811**

MARITAL CLINIC
Dr. Bernard L. Greene, Director

This is one in a series of advertisements describing some of the services offered at the hospital.

Obituaries

Maxwell P. Borowsky, Chicago, died November 29, aged 68. A graduate of Rush Medical College in 1920, he specialized in pediatrics and was former chief of staff in Cook County Children's hospital.

Edson F. Fowler*, Evanston, died December 7, aged 49. A graduate of Northwestern University Medical School in 1942, he was a general surgeon on the staff of St. Francis hospital. Doctor Fowler was also clinical associate professor of surgery at the University of Illinois College of Medicine.

Frank Glassman*, Chicago, died November 18, aged 58. A graduate of the University of Illinois College of Medicine in 1929, he specialized in orthopedic surgery. He retired to Miami Beach in 1963.

William A. Hoffman, Sr., Chicago, died December 8, aged 92. In 1921, he graduated from Chicago Medical School and was a staff member of the Chicago Eye, Ear, Nose and Throat Hospital until his retirement in 1952.

Daniel L. Horning*, Mount Morris, died November 19, aged 80. A graduate of the Hahnemann Medical College and Hospital in 1917, he worked as a medical missionary in China for seven years and was then on the staff of Bethany Brethren hospital until retirement.

Roy Keith*, Anna, died December 9, aged 68. A general practitioner, he had graduated from Northwestern University Medical School in 1924.

Harry A. Kraus, Chicago, died November 14, aged 80. A graduate of Northwestern University Medical School in 1906, Doctor Kraus retired in 1954.

Ladislav J. Meduna*, Chicago, died October 31, aged 68. A graduate of Eotvos Lorand Tudomanyegyetem Orvostudományi Fakultás, Budapest, in 1921, he specialized in psychiatry.

John Pellettieri*, Chicago, died October 25, aged 75. He was a graduate of Loyola University School of Medicine in 1916.

Albert D. Phillips*, Peoria, died November 26, aged 68. A graduate of the State University of Iowa College of Medicine in 1920, he was a staff member of Methodist hospital.

Frank V. Plummer, Chicago, died December 3, aged 74. A graduate of Chicago Medical School in 1920, Doctor Plummer specialized in dermatology and was formerly associated with the Chicago Board of Health.

Harry A. Salzman*, Chicago, died December 7, aged 72. A graduate of the University of Illinois College of Medicine in 1914, he specialized in pulmonary diseases. He retired in 1963 after five years as senior roentgenologist of the Municipal Tuberculosis Sanitarium where he had been associated for 40 years.

Paul W. Siever*, Glencoe, died November 29, aged 45. Chief of pediatrics at the Highland Park hospital, he had been a graduate of the University of Chicago School of Medicine in 1943.

*Indicates member of Illinois State Medical Society.

James R. Vaughn, Hamburg, died July 26, aged 94.



a Private Psychiatric Center at Jacksonville, Illinois, since 1901

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.

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Illinois Medical Journal

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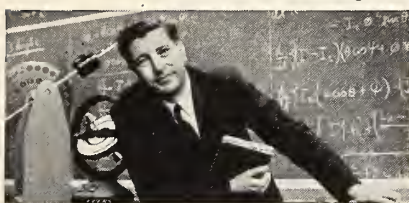
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**will calm your anxious working patient—
with little or no drowsiness**

When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll¹ used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration,

they were able to continue with and, in some cases, return to their daily work."

Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

Principal side effects, usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, *M. Press* 243:578 (June 29) 1960.



Smith Kline & French Laboratories, Philadelphia



AS I SEE IT FROM '360'

By ROBERT L. RICHARDS
Executive Administrator

BETTER CARE THAN MEDICARE

AS THE TITANIC STRUGGLE against federalized health care reaches its climax, one fact stands out clearly: if the medical profession is going to win, it must have the support of the public.

First and foremost the public must be told the FACTS about Medicare—that it is not only expensive and inadequate, but that it can impair and perhaps even demolish a free independent system which has continued to provide American citizens with the finest medical care the world has ever known.

To present these facts in a way that will effectively win and sustain public support, ISMS is preparing to implement an AMA-inaugurated communications program which promises to be one of the most intensive and comprehensive campaigns ever instituted by a state medical society.

The name of this program is "Operation ELDERCARE."

This month, the ISMS House of Delegates is meeting in special session to determine the mechanism of appropriating for this momentous program. With their approval, "Operation ELDERCARE" will be launched immediately with a broadside of public information emanating from every communications media.

There will be statewide radio and television announcements; newspaper ads; and informative brochures made available for direct mailings and pamphlet racks. In addition, service, social and business organizations all over the state will be encouraged to schedule physician-speakers to discuss medicine and public affairs.

Intensive and well-planned as this campaign

is, it cannot hope to succeed without the active support and personal endorsement of you, the physician. It is you and you alone who represent the last vital link of direct communications with the public.

How can you effectively offer this all-important individual support? The following points are suggested:

1. Learn the issues yourself and express them to friends, associates and patients whenever possible. The facts are easily obtained from booklets and brochures supplied by AMA and state and county medical societies.

2. Display pertinent literature on the subject in your office waiting rooms. An especially effective brochure demonstrating the disadvantages of Medicare as compared with those offered by independent plans is currently in preparation and will soon be made available in quantity for your office. Whenever possible public affairs literature should be included with your statements or other mailings to patients.

3. Volunteer as a member of your county medical society's speakers' bureau. Through "Operation ELDERCARE" your speaker's bureau chairman will be able to supply you with all speaker's materials including prepared speeches which are tailored specifically for the meetings at which they will be presented.

With your active cooperation, "Operation ELDERCARE" cannot help but achieve its goal—that of proving to the public with facts that an independent system of medical service provides

"BETTER CARE THAN MEDICARE."

ABSTRACTS OF BOARD ACTIONS

MEETINGS OF JANUARY 16-17, 1965

BOARD APPROVES 1965 BUDGET

Members of the Finance Committee, sitting as a panel, outlined the present financial condition of the Society, the budgets and salary schedules as they were presented by divisions, and asked for consideration of a \$718,200 budget for 1965. Various suggestions were made for eliminating an anticipated deficit of \$28,200, but it was decided to wait for final results of the "Voluntary Contribution" on the 1965 dues statement which may make up at least some of the anticipated deficit. Recommendations for eliminating future deficit budgets will be presented to the House of Delegates in May along with material regarding the future financial needs of the Society.

ISMS BEGINS IMPLEMENTING AMA PROGRAM IN ILLINOIS

ISMS began immediate implementation of the Board's resolution "to support the AMA national education program and pledge to execute a synchronized educational program in Illinois, and urge each member of the Illinois State Medical Society to support the AMA proposal and the educational program." A special meeting of the House of Delegates was called for February 7 to consider the final aspects of this program.

MANDATORY PKU TESTING OPPOSED

ISMS will continue opposition to mandatory phenylketonuria (PKU) testing of newborns and support the Public Health Department program to voluntarily conduct such laboratory tests primarily in private hospitals.

FAVOR LEGISLATION ON PHYSICALLY ABUSED CHILD

On recommendation of the ISMS Committee on Child Health, the Board voted to support a bill requiring hospitals, physicians and certain other medical and paramedical personnel to report to juvenile authorities cases of physically abused children coming to their attention. Proposed legislation provides the reporting party with immunity from legal action.

WARNS AGAINST DRAWING BLOOD FOR ALCOHOL TESTS

ISMS Legal Counsel Frank M. Pfeifer advised the Board that at the present time it is his opinion that "any physician who draws blood or authorizes some other person to draw blood for the purpose of making an alcoholic test from a person who is intoxicated violates a right of the individual even though permission for the test has been given and the physician would render himself liable in the event of a law suit." Copies of this opinion will be circulated to the secretary of each county medical society.

MATERNAL AND PERINATAL MORTALITY STUDY APPROVED

The Board approved a proposal for a state-wide study of maternal and perinatal mortality. The study will be made by a committee representing all interested medical groups in the state. By developing a uniform system of reporting and classifying cases of maternal and perinatal mortality, the committee expects to be able to recommend a program of action to reduce the incidence of these deaths.

(Continued on next page)

ABSTRACTS OF BOARD ACTIONS—(CONT'D)

MEETINGS OF JANUARY 16-17, 1965

ORAL POLIO VACCINE RESTRICTIONS URGED

In reviewing the growing problem of the prescribing of oral polio vaccine to be administered by a pharmacist or parent, ISMS has endorsed the position of the Illinois Chapter of the Academy of Pediatrics which says:

"Except for community-wide programs, the Sabin oral polio vaccine should be given only in physician's offices and under the direct supervision of a responsible individual in that office. This will insure the potency of the vaccine received by the patient and the safety factors needed to protect the community in the disposal of vaccine containers, and would provide continued supervision of the child's immunological status by a physician."

SEEK CHANGES IN FEDERAL WATER POLLUTION BILL

ISMS has notified sponsors of federal water pollution legislation that it objects to removing this activity from the public health service and favors giving states a voice in preparation of criteria of water quality.

BOARD ISSUES STATEMENT REGARDING PRESIDENT'S COMMISSION

The Board of Trustees has issued an official statement "that due to duplication of facilities, costs, and services rendered, the proponents of the President's Commission on Heart Disease, Cancer and Stroke do not necessarily express the feelings of the Illinois State Medical Society."

EXECUTIVE COMMITTEE TO MEET WITH DEANS

The Executive Committee of the Board of Trustees will meet with the deans of Illinois medical schools on Friday evening, March 12. A similar meeting in 1964 provided much valuable information which was presented to the 1964 House of Delegates.

ISMS TO CO-SPONSOR HOSPITAL CARE CONFERENCE

ISMS will be one of the sponsors of a series of nine conferences on the cost of hospital care. The conferences will be held in March and April under the auspices of the Health Improvement Association on the subject of hospital utilization.

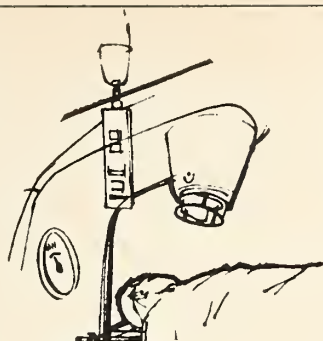
BENEVOLENCE FUND EXPECTS 1965 SURPLUS

On the basis of anticipated income from the voluntary contribution request on 1965 dues statements, the Benevolence Committee has budgeted a \$14,000 surplus while increasing payments to recipients by some \$7,000.

HEALTH CAREERS COUNCIL TO GET \$2,000

To help the Health Careers Council finance an ambition program for 1965, ISMS will contribute \$2,000. The council expects to conduct one health career conference in each of Illinois 103 counties and at least five conferences in the Chicago area.

MEDICAL PROGRESS



HARVEY KRAVITZ M.D. /progress editor

The Thymus

Recent years have witnessed a renaissance of study and attention to the function of the thymus gland. From a neglected role with only vague associations with such entities as myasthenia gravis, the thymus has suddenly burst onto the immunologic horizon with a veritable avalanche of experimentation and interest. This small gland is at the very heart of immunologic capability and seems to provide the most highly specialized environment for what might be termed the immunologic education of cells.⁶⁸

PROGRESS IN ALLERGY

PART 2 OF A THREE-PART SERIES

Samuel M. Feinberg, M.D., Raymond G.
Slavin, M.D. and Alan R. Feinberg, M.D.
/chicago

From the Departments of Medicine, Evanston Hospital, Evanston, Ill., and Northwestern University Medical School, Chicago, Ill.

Part of the work described in the manuscript was supported by Public Health Service Research Grant No. AI-04234 from the National Institute of Allergy and Infectious Diseases.

Although the thymus is rich in the small lymphocyte, an immunologically competent cell, it does not show production of antibody and does not respond to antigenic stimulation by producing plasma cells or germinal centers. It, therefore, behaves completely differently from other lymphoid structures in immunized animals.⁶⁹

Effect of Thymectomy: The first indication of the importance of the thymus in the immunologic makeup was the effect of thymectomy in the newborn. Mice thymectomized at birth develop normally for the first few weeks; then, after weaning, may die from wasting disease characterized clinically by weight loss, hunched posture, ruffled fur, and diarrhea, and death within a week. The earlier in life thymectomy is performed, the higher the incidence of wasting. After one week of age, thymectomy is no longer associated with development of the syndrome.⁷⁰ Similar syndromes have been described in the rat⁷¹ and hamster⁷² and bear an obvious resemblance to syndromes seen in graft versus host reactions, secondary disease in radiation chimeras, and parabiotic intoxication. In addition to fatal wasting disease, thymectomy of newborn mice is also associated with a marked decrease in the population of small lymphocytes in blood and tissue,⁷³ diminished capacity to produce serum antibodies to some antigens,^{74,75} and permanent failure of the capacity to reject tissue grafts not only from donors closely related to the hosts but also from distantly related donors such as rats.^{74,75} After one week of age, thymectomy is no longer associated with significant prolongation of survival of foreign skin grafts.

Miller's explanation⁷⁰ is that in the newborn, cells with immunologic potential are few or non-existent in non-thymus lymphoid organs. As the animal develops, these lymphoid organs receive from the thymus either a cellular or non-cellular contribution which endows them with their full complement of immunologically competent cells. Thymectomy in adult life would no longer be associated with severe defects, as other lymphoid organs can now carry on independently of the thymus. If the immunologic potential were to be destroyed or depleted, would the thymus again be required to restore this potential? To answer this question, Miller thymectomized adult mice and exposed them to total body irradiation. The results were a decrease in lymphocytes in blood and tissues, a failure to produce either primary or secondary antibody response, and a failure to reject foreign skin grafts in the thymectomized irradiated mice, but no such deficit in non-thymectomized irradiated controls.^{68,76} Therefore, the recovery of lymphopoietic and immune functions in irradiated adult mice is still dependent on a thymus controlled mechanism. Adult thymus may still be essential to re-establish the immunologic mechanism when the immune apparatus has been injured. In addition, Claman and Talmage⁷⁷ have shown prolongation of immunologic tolerance to bovine gamma globulin (BCG) in adult mice by thymectomy. Thus the evidence would seem to indicate that the adult thymus is active in the development of immunologically competent cells.

A possible clinical application is the performance of thymectomy in human renal homografts. Starzl⁷⁸ reports 5 patients with terminal renal failure treated with renal homografts. Total body irradiation and cytotoxic drugs were used to prevent rejection. In addition, the thymus and spleen were surgically removed prior to homotransplantation. Although the role of splenectomy and thymectomy in conditioning patients for receipt of a homograft is speculative, the early success rate in the thymectomized group which exceeds that generally attained with renal homografts warrants further attention.

Protection Against Effect of Neonatal Thymectomy: Suspensions of lymph node cells or spleen from normal adult mice have been found to be effective in preventing wasting disease,

and restoring the lymphocyte count and the immune mechanism. Presensitized lymph cells were also capable of breaking down an established skin graft on a neonatal thymectomized mouse.^{74,75} Mice thymectomized at birth and grafted within one week with intact thymus from a newborn donor develop normally⁷³ and could reject foreign skin grafts.⁷⁵ The question then arose as to whether the protection afforded by thymus implants was due to the production of lymphocytes which populate the host and restore immunologic functions. Miller⁷⁹ set up experiments using hosts whose cells were identifiable at metaphase by marked chromosomes. He found that the majority of cells multiplying in the host lymphoid tissue and thymus implants were of host type and could not have been contributed by the thymus donor. Therefore, there must remain in the neonatal thymectomized mouse a population of cells which can acquire immunologic competence but only in the presence of thymic tissue. The thymus probably exerts its influence by either producing a humoral factor which induces the maturation of immunologically competent cells wherever they may be, or by allowing differentiation of these cells within its own environment; that is, cells would invade the implant, differentiate in it and then colonize lymphoid tissue where they could function immunologically. The humoral factor thesis seems to be favored by experiments in which neonatal thymectomized mice were implanted with cell tight millipore diffusion chambers containing syngeneic (isologous) thymic tissue. These animals showed no signs of wasting or depletion of lymphocytes,⁸⁰ produced serum antibodies and rejected allogeneic skin grafts.^{81,82} These findings would suggest the elaboration of a diffusible thymic factor that acts upon seeded cells in lymphoid organs, but does not rule out the alternate concept of the thymic factor contributing to the establishment of immunologic competence within the environment of thymic tissue itself.

The Thymus and Autoimmune Disease: It seems likely that the thymus plays a greater part in the breakdown of immunologic tolerance than in the induction of tolerance. After total body irradiation the accelerated breakdown of immunologic tolerance occurs as the result of the differentiation of new immuno-

logically competent cells during the recovery phase.⁸³ Since the thymus is essential for the recovery of immunologic function after total body irradiation,⁷⁶ it seems likely that it is responsible for breakdown of tolerance under these circumstances. While tolerance breaks spontaneously in intact animals, it persists indefinitely after thymectomy. The breakdown of autotolerance and hence the development of autoimmune disease may also have some connection with the thymus. Many observations have been made concerning the relationship between the thymus and immunologic abnormalities in man. Aplasia of the thymus is associated with a condition known as essential lymphocytophthisis, marked by failure to thrive, wasting diarrhea, frequent infection, agammaglobulinemia and marked lymphopenia. The cause may be genetically determined agenesis of the thymus.⁸⁴ Hyperplasia of the thymus with germinal center formation is seen in the NZB/BL strain of mice with a genetically determined autoimmune hemolytic anemia.⁸⁵ Similar lesions in the thymus have been seen in patients with myasthenia gravis,⁸⁶ rheumatoid arthritis, thyrotoxicosis and Addison's disease.⁸⁷ Tumors of the thymus may be associated with clinical disorders which characteristically show either primary or secondary immunologic disturbances such as acute hemolytic anemia and thrombotic thrombocytopenic purpura.

Burnett has offered the theory that autoimmune diseases are expressions of disordered activity of clones of immunologically competent cells and that such clones, in common with normal immunologically competent clones, develop within and are distributed from the thymus.⁸⁸ Not only may immunologically competent lymphocytes with a wide range of specific antigen activity be derived from the thymus, but the healthy organ may have an inhibitory influence that discriminates effectively against mutating stem cells and their descending clones.⁸⁹ A recent report from the Mayo Clinic⁹⁰ tells of a young girl who developed ulcerative colitis, cirrhosis and systemic lupus erythematosus subsequent to thymectomy for myasthenia gravis. Another case has also been reported of lupus erythematosus following thymectomy.⁹¹

Utilizing the previously mentioned NZB/BL

strain of mice with hemolytic anemia, it was shown that autoimmune disease could be transferred to normal mice by neonatal exchange grafting of thymus gland derived from autoimmune strains. Neither thymectomy nor neonatal transfer of normal thymus prevents the development of autoimmune disease in the autoimmune strain.⁹²

Studies in Other Species on the Function of the Thymus: The chicken offers a rather unique opportunity to study thymic function. While it has no lymph nodes, it does possess an additional lymphoid organ, the bursa of Fabricius, which lies dorsal to the cloaca. The development of the bursa can be prevented by injection of testosterone propionate. In birds with a normal thymus but no bursa, there is no circulating antibody and delayed hypersensitivity is nearly completely inhibited. However, the rejection times of homografts are normal.⁹³ In birds with complete atrophy of the thymus and the bursa, rejection of skin homografts is prevented. Thymectomy in birds delays skin homograft rejection.⁹⁴ One can conclude that 2 and maybe 3 primary levels of lymphocytopoiesis are present in the bird, each controlling a population of cells concerned with different types of immunologic response.

Eosinophiles

The eosinophilic leucocyte has always constituted an object of interest to the clinician, because of speculation about its function and the striking appearance under the microscope. In 1846 Wharton-Jones described a leucocyte in the horse with coarse granular cells. But it was Paul Ehrlich, in 1879, who showed the affinity of the granules for eosin and named the cell "eosinophile." The size of the granules varies in different species, being fine in man and very large in the horse. The mature eosinophilic leucocyte has a pale staining nucleus, usually bilobed, sometimes trilobed. For many decades the association of eosinophiles with allergic states, other antigen-antibody reactions and parasitic infestation, has been an accepted phenomenon. The cells pour out in large numbers at the site of allergic inflammation, such as in the sputum in asthma, in nasal secretions in hay fever, and in biopsied tissues when allergic reactions take place. If the area of reaction is large and the process intense blood

eosinophilia will be increased. Parasitic infestation probably also produces eosinophile increase on the basis of an allergic reaction.

Eosinotactic Action of Antigen-Antibody Reaction: Numerous recent studies⁹⁵⁻¹⁰⁴ have experimentally confirmed, and elaborated on, the attraction of eosinophiles to the site of the antigen-antibody reaction. In 1932 Kline and co-workers⁹⁵ injected a 1:10,000 ragweed extract intradermally into non-allergic persons and those allergic to ragweed. Biopsies from the site of the injection of the non-allergic skin did not disclose eosinophiles. In the allergic skin eosinophiles appeared, beginning in 15 minutes, reaching a peak at 30 minutes and then rapidly declining. Cohen¹⁰⁴ and associates made observations on localized eosinophilia in the rabbit and other animals. Litt⁹⁷ produced peritoneal eosinophilia in the guinea pig by weekly i.p. injections of antigen, and determined the total number of cells by lavaging the peritoneal cavity. The optimum effect occurred at 24 hours after the challenging dose, and after 3 or 4 days the count returned to normal. When the tissue (peritoneal lining, lung, blood or serum) of an animal repeatedly injected with a foreign protein was transferred⁹⁸ to the peritoneum together with the antigen, peritoneal eosinophilia occurred. With transfer of sensitized lung no additional antigen was needed to produce eosinophilia. However, isolated instances of eosinophilia occurred even with transfer of extracts of normal tissues. Several years earlier Samter and his associates⁹⁶ had shown that lung tissue from guinea pigs which died in anaphylactic shock produced a marked transitory blood eosinophilia when transferred to the peritoneal cavity of a guinea pig. Antigen-antibody complexes, regardless whether equivalence or antigen or antibody excess were used, were found by Litt⁹⁹ to produce eosinophilia, but not when the antibody was absorbed by the specific antigen.

Archer¹⁰⁰ has conducted many investigations on horse eosinophiles. Repeated subcutaneous injection of ponies with bovine serum albumin followed by intradermal injection showed eosinophiles increased locally, most marked at 24 hours. Intramedullary challenge produced increased bone marrow eosinophiles, but decreased the blood eosinophilia. This is in line with the idea that blood eosinophilia represents

the passage of the cells en route from the bone marrow to the site of antigen-antibody reaction. Speirs¹⁰¹ demonstrated that adrenalectomy increases the eosinophilic response to an antigen. Under phase microscopy he observed¹⁰² that mouse eosinophiles were attracted to some mononuclear cells, penetrating and disrupting the cytoplasm but not the nucleus. After about the 4th day of inflammation the eosinophiles begin to die and are engulfed by viable macrophages.

That eosinophile increase may not require an antigen-antibody reaction is proposed by the report of Vaughn¹⁰³ who produced an elevation of blood eosinophiles in young guinea pigs by the injection of a protein-free *Ascaris* extract. Speirs¹⁰¹ induced local eosinophilia by asbestos filtered heparin or saline solution.

Eosinotactic Action of Histamine: Since the oldest and most accepted mediator released by the antigen-antibody reaction is histamine, it was but natural to suppose that this substance is responsible for the chemotactic attraction of eosinophiles. On this score, however, various investigators have reported conflicting results. More than 30 years ago Kline and his co-workers⁹⁵ reported that intradermal injections of histamine produced local eosinophilia in allergic persons, but not in non-allergic. Knott and Pearson,¹⁰⁵ in 1934, appeared to confirm these findings. Twenty minutes after an intradermal injection of histamine (0.05 cc of 1:10,000 histamine acid phosphate) the track of the hypodermic needle was opened with a surgical needle and the exudate from the wheal smeared on a slide. The percentage of eosinophiles in allergic individuals was greater than that in the blood and greater than the increase due to a specific antigen. The non-allergic subjects showed no change. They inferred that the eosinophile response to histamine injection could be used as a method of identifying an allergic individual. Rose and his associates, in reports to be described later, report similar findings with the skin window technic.

Archer¹⁰⁰ has been the major supporter of the idea that histamine is chemotactic for eosinophiles. After intradermal injection of histamine in ponies he found an increase of these cells locally. Litt¹⁰⁶ believes that the large amounts of histamine used by Archer, as compared to the small amounts liberated in the

allergic or anaphylactic reactions, might explain the discrepancy between Archer's findings and those of his and others. Litt injected from 0.1 to 100 mg histamine intraperitoneally into normal guinea pigs without provoking an increase in eosinophiles. Intradermal and foot-pad injections also gave negative findings when examined at intervals during a 24 hour period. However, an injection of 10 to 100 mg intravenously did increase the blood eosinophiles. Earlier, Vaughn¹⁰³ had shown an increase in lung and blood eosinophilia after an injection of 250 mg of histamine in guinea pigs. Perhaps the difference between the horse and other experimental animals and man is that the horse, as evidenced by his high percentage of blood eosinophiles, may actually be allergic in most instances, possibly because of frequent parasitic infestation. Archer also reports that in a preparation of a dried solution of histamine salt mixed with a drop of blood, examined by phase microscopy, the eosinophiles showed cytoplasmic granules collecting at the end of the cell.

Anti-Allergic and Antihistaminic Action of Eosinophiles: Archer¹⁰⁷ described a method of preparing eosinophiles from the horse. Using the whole cells or an aqueous extract of them injected locally, the response to a specific antigen was reduced in ponies.¹⁰⁸ The eosinophile extract also diminished the local eosinophilia from antigen and from histamine. Injected intradermally in ponies it diminished the edema from histamine and 5-hydroxytryptamine. Extracts from other leucocytes did not have the same effect. The bronchospasm in guinea pigs produced by an aerosol of histamine could be inhibited by the intraperitoneal injections of live eosinophiles or frozen, freeze-dried or aqueous extracts.¹⁰⁹ Not all horses have the same activities in their eosinophiles. Archer adds "Small numbers of human eosinophiles have been similarly studied and the results are comparable . . ."

It was also found by Archer¹¹⁰ that repeated intradermal injections of histamine in the same site in the pony decreased or abolished the histamine response and increased the eosinophiles. This finding is cited as another bit of evidence in support of the contention that eosinophiles counteract histamine. One might comment that there are alternative explanations (tissue in-

jury, paralysis of the vascular mechanism, etc.) as an explanation of the reduced edema. Furthermore, although the timing of our experiments¹¹⁰ was not the same, we failed to obtain a marked influence on the localized edema in man from repeated intradermal injections of histamine.

In Archer's experiments¹⁰⁰ the effect of eosinophiles on the edema reaction of the pony to histamine was present only when the histamine was administered within an hour of the eosinophile injection. However, eosinophile extracts (4 to 5 million) had a similar antihistaminic effect in the pony. By injecting an extract of his own eosinophiles the edema reaction from histamine (1 mcg.) was reduced.

Broome and Archer¹¹¹ attempted to throw light on the mechanism of histamine antagonism by eosinophiles. Batches of equine eosinophiles were incubated with histamine acid phosphate, in the proportion of 300×10^6 eosinophiles to 125 mcg. of the histamine salt in 3 ml saline. A similar number of eosinophiles was added to saline without histamine. The mixtures were incubated at 37°C for 30 minutes, the cells separated by centrifugation at 2000 g for 3 minutes, the supernatant discarded and the deposit washed with saline. The cells were suspended in water and an extract made by ultrasonic disintegration and removal of insoluble debris by filtration. Both extracts were tested for their effectiveness in inhibiting the edema produced by histamine in the pony's skin. The extracts of cells incubated with histamine were no longer capable of inactivating further histamine. In paper electrophoresis of the eosinophile-histamine preparation histamine could not be demonstrated by the ninhydrin reaction, although when eosinophiles which did not inhibit histamines were added, free histamine could be demonstrated.

Skin Window: Quite recently there has been a revival of interest in studying the cytology of allergic inflammation, and particularly the role of eosinophiles, by a technic termed the "skin window." As early as 1940 Rebuck¹¹² examined the exudate on a glass cover slip placed on an abraded area of the rabbit's ear. Several years later^{113,114} he applied this technic to the human skin. An area of the skin several millimeters in diameter is abraded to the dermis, a cover slip is applied and fastened with

adhesive, the cover slip is removed at desired intervals and replaced by a new one, and the slips are stained and examined microscopically. This gives a picture of progressive cellular exudation from inflammation due to trauma. The effect of various antigens, such as immediate reacting antigens, and antigens producing delayed reactivity, can be studied in this manner. The general events in mechanical inflammation¹¹⁴ are a preponderance of neutrophilic polymorphonuclear cells at first, with increasing monocytes, which predominate by the 14th hour. At that time macrophages and degenerating leucocytes appear.

The mechanical inflammation is modified by the blood picture.¹¹⁴ When monocytes are increased in the blood they are also increased in the skin window. As early as 1940 Rebeck¹¹² showed in the rabbit that local infection with *Listerella monocytogenes*, after systemic infection and production of a high blood monocytosis, produced monocytogenous macrophages in the skin window. In a case of cyclic neutropenia Page and Good¹¹⁵ found no neutrophils in the skin window during the neutropenic stage. Furthermore, they noted a marked diminution of lymphocytes and monocytes on the cover slip. They theorized that the polymorphonuclear cell or a product of its reaction with connective tissue elements, contributing to the inflammatory process and provokes invasion of lymphocytes and their transformation to macrophages. Experimental observations in rabbits¹¹⁶ confirmed this suspicion. Animals were made temporarily neutropenic with nitrogen mustard. Viable leucocytes obtained from inflammatory exudate of another animal injected into the skin of the rabbit provoked exudation of lymphocytes, while leucocyte homogenates or other control inflammatory materials failed to do so.

Eidinger and associates^{117,118} studied the eosinophilic response from an application of an antigen and related substances by the skin window technic. An antigen (such as ragweed) applied to the skin of an allergic individual showed eosinophile increase at 4 hours, maximum at 24 hours, and still present at 48 hours. Passively sensitized sites gave similar but not as intense sensitivity. Heating of the serum abolished the eosinotactic activity. Topical steroids did not influence the eosinophile response,

while Phenergan orally increased it. A histamine solution applied to the abraded area showed some eosinophiles in 1 to 4 hours in allergic individuals, but not in non-allergic. Fowler and Lowell¹¹⁹ confirmed part of these findings.

In subjects with blood eosinophilia ranging from 14 to 60% Torre and Leikin¹²⁰ obtained very few eosinophiles at the skin window (no antigen applied) in some, while in others a large percentage of eosinophiles resulted. Eitzman and Smith¹²¹ used the skin window to study the inflammatory response in infants. The study was prompted by the fact that infants fail to exhibit the usual signs of inflammation to foreign substances, viruses, etc. The striking finding was the appearance of eosinophiles, varying from 2 to 93% in the preparations in infants less than 3 weeks old, the findings being maximal at the 2 hour period after traumatization of the skin.

Delayed types of hypersensitivity have generally been regarded as on a mechanism different from factors involving antigen-antibody responses, histamine release, or eosinophile participation. Some skin window studies appear to challenge this view. For example, using Rhus antigen in Rhus-sensitive persons Hu and associates¹²² found 10-40% eosinophiles at the 33-48 hour stage. Fulton¹²³ made some similar observations in tuberculin hypersensitivity. On the other hand, neither Rebeck and Yates,¹²⁴ nor Braunsteiner and his associates,¹²⁵ in extensive observations with tuberculin or tularia sensitivity, mention the finding of eosinophiles.

In spite of these and other contributions, the role of the eosinophile in allergy, from a basic or diagnostic standpoint, is not yet settled. The experienced clinician is aware that there are too many instances of presumed allergy where large numbers of eosinophiles are found, for example, in the sputum or nasal secretions, and yet no specific extrinsic allergy can be located. Alternative explanations for this phenomenon is the presence of extrinsic allergy of unidentifiable source, the possibility of intrinsic (auto-immune?) allergy being responsible, or the further possibility that other mechanisms than allergy may release mediators responsible for eosinophilia. Indeed, the demonstration of many years ago that mechanically induced emphysema in the dog, and our experience that

in at least some cases of primary emphysema with secondary bronchial obstruction in man increased percentage of blood and sputum eosinophiles are present, is a support of this view. The absence of eosinophiles in sputum or nasal secretions of patients with a history of non-infectious asthma or rhinitis also is a puzzle. It is possible, on the basis of some of our experimental findings¹²⁶ of delayed atopic-like symptoms produced in induced delayed hypersensitivity, with an associated lack of eosinophiles, that some similar spontaneous symptoms might possibly be on a delayed hypersensitivity basis.

Auto-Immunity

The concept of auto-sensitization, the ability of man or an animal to become sensitive to one's own tissues, is not a new one. Around the turn of the century such pioneers as Bordet, Uhlenhuth, Ehrlich and Morgenroth, and Donath and Landsteiner, demonstrated it experimentally in animals and clinically in man. However, the concept of auto-sensitization as the pathogenesis of common clinical manifestations has attracted great interest and experimentation primarily in the last several years. The literature has become replete with clinical and experimental reports and a number of textbooks have been written on the subject. In the limited space at our disposal it will be impossible to handle this subject adequately. Our primary aim, therefore, will be to present a rather spotty review, particularly of recent developments, in the hope that it may serve the reader as a starting point for further more detailed reading.

In general, the evidence for auto-sensitization is as follows: In a number of types of organic diseases one or more antibodies against the tissue involved have been found. But, as the most vehement protagonist of the concept of auto-immunity would admit, such antibodies could as well be the *consequence* of the disease as the *cause*. Indeed, it is pretty well demonstrated, in myocardial infarction, that following death of heart muscle tissue heart antibodies develop. Furthermore, in most instances of naturally developing human auto-antibodies these have not been shown to be cytotoxic. Most immunologists now hold to the view that the circulating antibodies are only symptoms of disturbed anti-

body formation and that if the disease is truly of auto-immune origin the mechanism is a cellular one, of the delayed hypersensitivity type. Experimental autosensitization in animals most always requires adjuvants and although circulating antibodies are produced it is generally agreed that the damage to the tissue is probably on a cellular mechanism.

We shall now recount briefly some experiences of investigators in several groups of conditions, both clinical and experimental.

Thyroid and Other Glands: In 1956 Rose and Witebsky¹²⁷ reported that the thyroid gland of rabbits injected with rabbit thyroid extract in Freund's adjuvant contains smaller amounts of thyroid antigen than do normal rabbits. This diminution of the thyroid antigen could also be demonstrated by the decreased inhibiting effect of hemagglutination of tanned red blood cells. Histologic examination of the glands showed marked changes, the maximum changes correlating with the higher level of antibody titer. Witebsky and his associates¹²⁸ showed further that thyroid antibodies could be found frequently in man in chronic thyroiditis. At the same time Doniach and Roitt¹²⁹ reported the finding of precipitating antibodies against thyroglobulin in the serum of patients with Hashimoto thyroiditis. The antibody was organ specific and did not cross react with thyroid extracts of 6 other mammalian species. Felix-Davies and Waksman¹³⁰ succeeded in transferring experimental thyroiditis from sensitized guinea pigs to guinea pig recipients by transferring donor lymph node cells. Three of the 7 recipients tested to thyroglobulin intradermally gave a delayed positive reaction.

There is great clinical interest at the present time in the use of antibody tests in diagnosis. Doniach and Roitt¹³¹ summarize the situation. The precipitin test is the most reliable index of severe thyroiditis, but it is positive in only 45% of Hashimoto cases. The latex agglutination test with thyroglobulin is more sensitive but is still negative in a large portion of these cases. Tanned red cell agglutination is 1000 times more sensitive than the precipitin test, giving results in 95% of Hashimoto cases, but also producing some false positive reactions. From the pathogenic viewpoint microsomal antibodies are probably most important, and are found in high titer practically only in Hashimoto's disease,

myxedema and hyperthyroidism. The fluorescent technic is the most sensitive and specific for microsomal antibodies. Other tests used are cytotoxicity in tissue culture and complement fixation.

Freund and associates,¹³² in 1953, produced aspermatogenesis in guinea pigs by injection of testicular tissue in adjuvants. Waksman¹³³ described the auto-allergic lesions in such guinea pigs as consisting of perivenous inflammation with invasion of semineferous, epididymal and rete tubules, destruction of tubular contents, atrophic orchitis and aspermatogenesis. He says that the pathology is similar to that of the orchitis of mumps. The question of human sterility as a result of autosensitization has been raised for a long time. Rümke and Hellings¹³⁴ studied the spermagglutinins of 2015 males of sterile couples. Three per cent had antibodies, while none of the 416 fertile men showed any. In the positive cases auto-agglutination was sometimes present. The authors regard their findings to indicate the presence of an auto-antibody, which may account for some cases of sterility.

Antibodies to pancreas were produced by Witebsky and his group.^{135,136} Pancreatic extracts of man, dog, hog and cow, were injected intradermally with Freund's adjuvant and intravenously. Pancreas specific antibodies were demonstrated by complement fixation, tanned cell hemagglutination and precipitation in agar gel. Sera of rabbits immunized with pooled rabbit pancreatic extracts contained antibodies to some of the rabbit pancreas antigens, but not to the pancreas preparation from the *same* animal.

Auto-antibodies to the adrenal gland have also been produced. In Addison's disease Anderson and associates¹³⁷ found complement fixing antibodies to human thyroid and adrenal gland in 2 of 10 cases examined.

Nervous and Muscular Systems: The concept that certain diseases of the nervous system might be on an intrinsic allergic basis has existed for a long time. Post-vaccinial and post-measles encephalomyelitis have been regarded as on an allergic basis. But in such and similar instances the question is whether the allergic inflammation is due to microbial sensitivity or to injured nervous tissue acting as an antigen. Here we shall discuss briefly the experimental

developments which aim at production of demyelinating disease which resemble the demyelinating disease in man. According to Adams¹³⁸ these are: acute necrotizing hemorrhagic encephalitis, acute disseminated encephalomyelitis, acute and chronic relapsing multiple sclerosis, and Schilder's disease.

In 1935 Rivers and Schwenkter¹³⁹ produced encephalomyelitis with myelin destruction in monkeys by injecting brain tissue without adjuvants. Later Freund and his associates¹⁴⁰ demonstrated that the use of adjuvants gives the experiment greater chances for success. Paterson and Bell¹⁴¹ introduced allergic encephalomyelitis in rats by sensitization to homologous or guinea pig spinal cord with incomplete adjuvant (without mycobacteria). To sensitize guinea pigs, however, a complete adjuvant was needed.

Experimental allergic encephalomyelitis cannot be transferred by serum to a recipient animal. Lipton and Freund¹⁴² were able to transfer this disease in rats by parabiosis. However, the experiments were not altogether successful because the encephalomyelitis in the *donor* rat was mitigated by this procedure. By injecting lymph node cells from donor rats sensitized to spinal cord allergic encephalomyelitis was produced in the recipients by Paterson.¹⁴³ The transfer was most frequent when the recipients were pre-treated with spleen cells of the prospective lymph node cell donors. A symposium on "Allergic Encephalomyelitis" edited by Kies and Alvord¹⁴⁴ covers the subject thoroughly. It may be added that the experimental findings promise to contribute materially to an early solution of some of the problems in human disease of the nervous system.

In 1960 Strauss and co-workers¹⁴⁵ described the staining of alternate striations of human skeletal muscle with labeled γ -globulin from a large proportion of cases of myasthenia gravis. Since then a number of reports have been presented which would tend to indicate that a specific anti-skeletal muscle antibody is present in this disease. However, as we have pointed out earlier in connection with other antibodies, this does not prove either that the antibody is the cause of the disease nor, indeed, that it represents anything more than a response to the destroyed muscle tissue as an antigen.

Part 3—"Auto-Immunity"— to be continued in next issue

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DRUGS AND THE CHANGING CAUSES OF DEATH

Man's progress in the field of medicine over the last half century has been phenomenal, and the pharmaceutical industry is proud of the part that it has played. It is only necessary to reflect on significant changes that have come about in the relative position of the leading causes of death at the beginning of that period. Accidents were twenty-eighth on the list of causes of death and now are fourth. Accidents today constitute the leading cause of death among children five to fifteen years of age, whereas rheumatic fever occupied this position fifteen or twenty years ago. Tuberculosis, once "the captain of the men of death," is now seventeenth on the list and will go lower.—Alfred E. Driscoll, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine*, 270:6, (Feb. 6,) 1964.

Magnitude of the Problem

THERE ARE APPROXIMATELY 70 MILLION SMOKERS in this country and at least half of them need medical advice, because they either smoke too much, or because they are affected with some disease which is aggravated by smoking. It is not easy to determine the criterion of excessive smoking, but statistically, over one package of cigarettes seems to characterize the heavy smoker, whose morbidity and mortality are markedly increased over those of the non-smoking population¹.

Physicians have definitely cut down on their smoking, the latest figures being those obtained by a questionnaire in Modern Medicine. The present percentage of physician smokers seems to be around or below thirty percent, a vast drop from seventy percent in 1949.² Personal observations indicate that this hard core of 30 percent are more vociferous and more rebellious against any measure which would tend to prevent or reduce the amount of smoking in the general population. In fact, it would seem, as will be discussed below, that such people need to smoke to satisfy their compulsive nature and that perhaps another habit or drug taken up as a substitute might be more harmful than tobacco. It should be remembered too, that the smoke-filled room of the politicians or the smoked-choked atmosphere of a medical meeting in the past is analogous to the Betelnut chewing of native gatherings, or even those of the lotus-eaters, who away from home, are floating in their dreamland oblivious to next morning's headache, dry taste in the mouth and esophageal reflux.

What physicians face individually and as members of organized groups, is the recognition of a grave responsibility, not only to themselves and their families, but to their patients and to their community. The medical profession has always resented governmental regulation of health problems, even though certain public health measures taken against epidemics, water pollution and air pollution must necessarily transcend local or state control. But in the case of the tobacco-injury, very little effort has been expended so far in education of the public on prevention of the habit in school children or helping the adult to stop smoking.

SMOKING WITHDRAWAL: THE PHYSICIAN'S ROLE

Geza de Takats, M.D., M.S., F.A.C.S./chicago

Clinical Professor of Surgery, Emeritus, University of Illinois, College of Medicine; Consulting Surgeon, Presbyterian-St. Luke's Hospital; Past President, Chicago Heart Association; Chairman, Chicago Heart Association, Committee on Smoking.

Some concerted action among voluntary health agencies on a local and national level may well lead to the formulation of simple, inexpensive and effective approaches. So far, the granting agencies including the Tobacco Industry, have skirted the issues with a dignified stalling device of trying to find out more and more about what is clearly obvious.

Types of Smokers

Whether an individual starts to smoke as a teenager (even a pre-teenager) or as an adult, depends on a large variety of factors. What is of immediate value is the recognition of the type of people who can stop. Because there are people who never can, it is well for the individual physician, or for a withdrawal clinic to recognize such a patient, since the customary and rather superficial methods commonly employed are bound to fail. It is well, therefore, to classify such individuals in one's mind before undertaking any effort of tobacco withdrawal.

Much of my own experience with smokers has suddenly crystallized on hearing Charles C. McArthur speak on the "Personal and Social Psychology of Smoking".³ Non-smokers, whether pious or not, have remained old-fashioned enough to remain "inner-directed". They would rather stay home at night, belong to a few societies rather than to many, dream of a scientific career rather than a sales manager's job. If such a person should start to smoke, he will not smoke heavily, will stop intermittently and can readily stop any time. Such an individual, if told he must not smoke because of reasons of health, will instantly stop and will have no withdrawal symptoms.

At the other extreme is the habitual smoker, and the more he has smoked, the harder it will be for him to quit. Studies on Harvard Alumni showed that the average daily number of cigarettes smoked by adults who can stop is 9, for men who don't try to stop is 18 and for those who cannot stop it is 20. Of course, the heavy smokers of over one package of cigarettes a day, have a number of psychiatric labels which I will here ignore. Suffice it to say, that the very fact that he smokes over a package of cigarettes a day has characterized him (or her) to show considerable resistance to withdrawal.

There is much argument about habit versus

addiction in these people. Recently a persuasive argument has been presented to the effect that a number of gradations exist between these two modalities.⁴ From a standpoint of withdrawal, addiction simply presents a more deep-seated resistance to changing a deep-seated habit.

Between the two extremes are the majority of moderate smokers, whose intelligence, will-power, social background and insight into an impending danger (if such should exist) will determine the feasibility to wean them away from tobacco. Incidentally, McArthur's statistics showed³ that the ability to stop smoking is directly proportional to the number of months his Alumni were fed from their mother's breasts. Light smokers who could stop were weaned at 8.0 months; heavy smokers who could stop at 6.8 months. Smokers, mostly heavy, who tried to stop, but could not were weaned at 4.7 months. As the author pointed out, there is no need to postulate that infantile frustration and adult cigarette smoking are cause and effect. It simply means that late weaning is associated with those personality traits that are also related to the ability to stop smoking.

Methods of Withdrawal

A. The Individual Physician's Role: The obvious necessity to stop smoking for certain patients affected with broncho-pulmonary disease, peripheral vascular disease, clotting phenomena or duodenal ulcer—just to mention a few important entities—make it important for each physician to use a number of staged methods to obtain abstinence from tobacco. A procedure has gradually developed which has been successful at least in a vascular surgical service for the last 40 years:

1. On the first examination, the futility of any therapeutic measure while smoking is continued, is stressed. In patients suffering from thromboangiitis obliterans,⁵ treatment is not undertaken until smoking has stopped.

2. If time permits and a patient needs direct evidence, a smoking test is performed. This is kept quite simple and can be carried out in any examining room without temperature or humidity control.

Pulse, blood pressure and the temperature

of fingertips are recorded before and two, five and twenty minutes after the smoking of the patient's own cigarettes at the rate he is accustomed. This will lead to a rise in pulse and blood pressure and a fall in finger or toe temperature in the majority of individuals.⁶ In tense or hypertensive individuals, or if the environment is cool, a pre-existing vasoconstriction can mask the effect of smoking and the smoking test may have to be repeated in a more basal state or in a warm room.

3. If the patient is a candidate for a surgical procedure, the incidence of postoperative atelectasis is 2-5 percent in non-smokers versus 30 percent in smokers.⁷

4. During hospitalization, complete abstinence from tobacco is prescribed. This is not difficult for the patient, since his pre and postoperative medication, the preoperative study and the immediate convalescent period divert his interest from tobacco.

5. If symptoms of withdrawal, such as restlessness, insomnia, salivation, excessive perspiration and water retention develop, these are promptly treated. Lobeline is injected in 20 to 50 mg. daily divided doses according to Eyrup's schedule.⁸ This is followed with decreasing amounts of lobeline in tablet form, each tablet containing 0.5 mg. of lobeline. For the bradycardia, salivation and excessive perspiration, anticholinergic drugs are used; belladonna-phenobarbital is remarkably helpful. For water retention, which may well explain the immediate weight gain, dextedrine sulfate is used, which inhibits antidiuretic hormone production. Dextedrine sulfate is also indicated to depress increased appetite and to mobilize free fatty acids from the fat stores, which may be slowed down when the nicotine-induced output of catecholamines is reduced.

6. As little sedation as possible is given outside of the usual sleeping tablet at night. The use of tranquilizers may readily shift the patient's addiction from tobacco to meprobamate or chlorpromazine, an undesirable situation encountered also in alcoholics.

7. The patient's hospital stay need not be longer than two weeks, as far as nicotine withdrawal is concerned. He or she is discharged on a low cholesterol, low calorie diet and small 5-10 mg. doses of dextedrine, the triple action of which has already been discussed.

A spot check of the last 100 consecutive patients indicate that there were 30 smokers, 58 non-smokers, and in 12 the smoking habits had not been registered, truly a grievous error in a biased sample of vascular patients. Of the thirty, 7 continued to smoke, a 20 percent failure rate. However, out of these 7, five cut down on their smoking from an average of 1½ packages to 8 cigarettes a day, whereas 2 patients, both suffering from advanced cardiovascular renal disease, continue to smoke 30 cigarettes daily.

Of the 30 smokers, only three had to be given the full withdrawal treatment including lobeline, belladonna and dextedrine. All three were heavy, compulsive smokers, with emotional conflicts, alcoholism or narcotic addiction. The follow-up period in these is less than a year, but so far there has not been a relapse. As will be brought out later, a five-year follow-up is probably necessary before one can speak of successful withdrawal. A recently re-examined patient, who underwent bilateral lumbar sympathectomy for Buerger's disease in 1935, has started smoking after 29 years of abstinence with a prompt flare-up of a superficial phlebitis.

B. The Withdrawal Clinic: It has been stated in the introduction, that the smoking habit is so prevalent in the United States, that it would be impossible to influence it by individual physician-patient relationships. A true smoking withdrawal clinic may be defined as an interpersonal linkage between a counselor (usually, though not always a physician) and a group of people who desire to break the smoking habit. There are a number of withdrawal clinics, both abroad and here, and they have recently been surveyed by a working conference.⁹ In addition, "anti-smoking clubs", "smokers-anonymous" groups have sprung up in different areas organized by ex-smokers and seemingly have a slow, but effective impact on the non-participating general population.

On a single experimental set-up organized at the Chicago Heart Association,* four meetings were held in the evening at weekly intervals.

*Miss Lois Stachnik, B.S., has done a great deal of work in organizing this Clinic. Harold Levine, M.D., Head of Chest Services, Cook County Hospital, led the discussion periods.

TABLE 1.

REGISTRATION AND STATISTICAL SHEET
CHICAGO HEART ASSOCIATION
ADVISORY SESSIONS ON SMOKING AND HEALTH
APRIL 7-14-21-28, 1964

1. Number of years you have smoked _____
2. Have you smoked cigarettes? _____ cigar? _____
pipe? _____ chew? _____ use snuff? _____
3. How much have you smoked (average per day)?
No. of pkgs. _____
No. of cigars _____
No. of pipefuls _____
Amount of chewing tobacco _____
Amount of snuff _____
4. Have you ever seriously tried to stop before?
Yes _____ No _____
Stopped abruptly: Yes _____ No _____
Tapered off _____
5. What is the longest time you have been off tobacco
previously?
None _____ Weeks _____ Months _____ Years _____
6. How did you learn of this program? _____
7. Why do you want to stop? _____
8. Occupation _____
9. Marital Status _____
10. Do you have children? _____
11. Name _____
12. Address _____
(street) (city) (state) (zip code)
13. Phone _____

The format included lectures, films, slides, posters, literature and group discussion. The programs were designed for a group of 20-25 persons to serve as a pilot study. The participants were asked to fill out a Registration and Statistical Sheet (Table 1).

Attendance varied from 15 to 8 participants with 5 to 6 observers, who were either ex-smokers or who came to evaluate the program and enter the group discussion.

Following the fourth session, a simple questionnaire was mailed to each participant and a final session of evaluation was held (Table 2).

The consensus of opinion, both of the participants and of the observers, was that an approach to changing the habits of smokers can be profitably pursued on a group therapy basis, that an ex-smoker is the most logical and successful type of leader for the discussion and that a combination of a group discussion leader and a physician seemed to work well. Since other voluntary health agencies have recently combined to form in this State a Co-Ordinating Committee on Health and Smoking, all further planning of sessions will be done in co-operation with this committee.

C. Other Actions. A mailing stuffer warning the public about the hazards of smoking is to be included in all out-going mail of the Chicago Heart Association. In addition, two posters released by the American Heart Association are mailed to each of our 1700 physician members. Since, of 192,000 physicians queried about smoking habits, 94.8 percent of the 60,202 who responded felt that smoking was hazardous to health, one can expect excellent co-operation from the practicing physician, if he is given the proper role in this area.¹⁰ As it is, the practicing physician is expected to do so much preventive medicine, that he should be given the appropriate tools to work with.

Requests for speakers on the subject of tobacco and health now reach the voluntary health agencies at an increased rate. This seems to be an excellent opportunity for physicians to disseminate factual knowledge to the public or or debate with inveterate smokers on a public platform. A close inspection of such activities reveals, however, that the overworked physician who may sacrifice two or more evenings a month to such activity, will find himself addressing metropolitan, suburban or exurban crowds of varied size and quality. The program directors of various groups have a difficult time

TABLE 2.

EVALUATION SHEET
ADVISORY SESSIONS ON SMOKING AND HEALTH
CHICAGO HEART ASSOCIATION

- Date _____
1. Check each meeting attended: 1 _____ 2 _____ 3 _____ 4 _____
 2. Did you attend the sessions to: (Check One)
Stop smoking entirely _____
Modify your smoking habits _____
Not acquire the habit _____
 3. Did you accomplish what you hoped to?
Yes _____ No _____
 4. If No, did you benefit in any way from the program? _____

 5. What do you feel was most helpful in the sessions?

 6. What did you find least helpful? _____

 7. Other comments about the program _____

 8. Name _____

scheduling appropriate topics for weekly or monthly lectures and by the time the group gets to the problem of smoking, it has been addressed on alligators to zebras. Under such circumstances, the impact of even an experienced and dedicated speaker on an important menace to health is doubtful and had better not be measured. There is so much more he can do at the office, at the hospital and at medical gatherings, if he is truly interested in smoking withdrawal.

The Physician and the Mass Media

There is no need to re-emphasize the potent and aggressive advertising campaign of the Tobacco Industry. Not only the practicing physicians, but large and respected medical organizations can never match the funds for such a campaign, nor would it be proper to spend money—the public's money—on such a course. This is not to say, however, that if a Voluntary Health Agency, whose policies are ultimately determined by physicians, has something positive and clear-cut to say in the matter, it should issue statements to the press, radio and television. In fact, Interagency Committees are even more effective.

The basic difficulty facing the scientifically trained physician is, that contrary to an industry trying to sell a popular and well established product, it cannot speak in black and white, in dogmatic and unproved facts; it has to rely on a slow groundswell of understanding. An editorial in the *Annals of Internal Medicine*¹¹ believes that the attitude, the example and the influence of the family physician could, in time, make the ashtray as obsolete as the cuspidor.

There are, of course, sound medical reasons for advising an endangered group of patients to stop smoking. Such patients have bronchitis, emphysema, heart disease, atherosclerotic arteries, thromboangiitis obliterans, recurrent thromboembolic phenomena, hypertension, peptic ulcer and a number of other conditions, which smoking definitely aggravates. No attempt is made here to enumerate a full list of such disease entities. They are only listed to indicate that many patients are not emphatically urged to stop smoking, even in the presence of the above mentioned conditions.

A group of "high-risk" individuals thus needs

to be defined. They are those with a history of lung cancer, heart disease, stroke and/or hypertension in their families at *middle age*; furthermore, diabetes, high levels of cholesterol or triglycerides and other factors associated with greater proneness to atherosclerosis.

Legislative Action

To date, over 20 nations have announced various activities intended to reduce tobacco consumption. Each of these countries has mounted an antismoking propaganda campaign with the help of booklets, brochures, pamphlets, posters and billboards. The Tobacco and Cancer Committee of the American Cancer Society has summarized these measures.¹² In this country, following the Surgeon General's Report,¹ the Federal Trade Commission started some hearings in regard to labeling of cigarettes as being injurious to health. As a response to the threat of legislation, a Cigarette Industry Advertising Code has been developed, which if properly enforced, should remove many of the objectionable features of tobacco advertising. Some State Medical Societies, including Illinois, have brought in firm resolutions to the House of Delegates of the American Medical Association, as a result of which, this body issued a strong statement in recognizing tobacco as a health hazard at the June 1964 meeting in San Francisco.

It should be stressed that the problem is a medical one, which must be shouldered by all physicians, not only individually, but also through various of their agencies and organizations. A close co-operation between voluntary health agencies and by Federal agencies is desirable, and the important point is not to let political, financial and business interests deter the physician from the issue on hand: Can he alone, or as a member of a national, state or local medical organization, influence the widespread smoking habits of teenagers, the excessive, compulsive smoking of adults and is he willing and able to treat the habituated or addicted smoker?¹³

Discussion

Since the medical population does contain a sizable and devoted contingent of smokers, this group can naturally not operate with any

success in this field. Nevertheless, individual physicians who feel unable or are unwilling to discontinue smoking, should abstain when exercising their professional duties. This goes for the house staff of hospitals, too. "Is the physician who does not warn his patients about the dangers of cigarette smoking, negligent?"¹⁴

But there is a majority of physicians who do not smoke, or who have quit smoking and who are perfectly willing to help in an individual or organized way, if and when the proper data reach them. This has not happened to date. The Surgeon General's Report is highly informative, but is only the first step in professional education. There are indications, that Co-ordinating Committees of Voluntary Health Agencies are preparing booklets, not only about the health hazards of tobacco, but about ways and means to stop smoking. It seems likely, that just as in the case of alcohol addiction, not only withdrawal clinics, but withdrawal specialists may develop in the field of smoking. He will have to apply not only various useful methods of withdrawal, but treat the physiologic and psychologic effects of abstinence. If the family physician is too busy or not interested in methods of tobacco withdrawal, but still convinced of the value of such an endeavor, he might reasonably send his patient to a man or a group who is willing to develop time for and skill in these methods. While warnings and regulations may have a deterrent effect on the public, their greatest value lies in producing self-regulatory measures on the part of the tobacco industry. Such a trend is discernible at this time.

As a result of our observations in private practice and in a small experimental withdrawal clinic, the smoking population cannot be looked upon as a single, homogenous group. There are many sub-groups as far as smoking behavior is concerned, and they range from non-habituated, and finally to an addicted group. These must be clearly defined and separated from each other, since each requires a different approach.

The value of anti-smoking clinics not only consists of helping a number of people to stop,

but they indicate that the medical profession as a whole and as individuals recognizes the tobacco hazard; they also serve as "non-smoking islands", on which the struggling and frequently relapsing smoker can land when he wants to.

Summary

The majority of physicians have expressed their belief that smoking is hazardous to health. There has been, however, neither a sizable individual nor an organized attempt to transmit and implement this belief to the public. While mass media are beginning to inform the population about the pro's and con's of tobacco consumption, the majority of physicians, with some notable exceptions, have taken an indifferent attitude; some have even taken a cue from industry and speak about curtailing the freedom of the consumer. The duty of the medical profession as a whole and as individuals, is to inform the smoker about what he is doing to himself and to his family. The increased morbidity of the smoker is putting an increased burden on his community and indirectly on the whole country.

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DIAGNOSIS AND MANAGEMENT OF ANTERIOR UVEITIS

G. Victor Simpson, M.D./Washington, D.C.

UVEITIS IS A DISEASE best guided with abundant clinical experience. It may respond most satisfactorily to proper management without etiological surveys or it may resist the most carefully carried out plan of study and treatment. Clinical experience furnishes the insight and the determination to follow through with an adequate investigation and provides the judgment that valuable but potent therapeutic agents be employed with safety, but with the assurance of obtaining their maximum effectiveness.

The problem of uveitis generates a feeling of confusion and frustration but fortunately with a careful examination, orderly investigation and treatment the majority of cases do well. There are a few exceptions but even when the case is not cured, thoughtful management accomplishes a great deal in reducing the severity and frequency of the attacks and sustaining useful vision.

It is essential that the main area of the uveal tract that is involved be determined as promptly as possible. This conclusion can only be reached after a clinical examination of both eyes using all the tools that are available. With the information it should then be possible to make use of this classification.

A. Anterior Uveitis

1. With non granulomatous reaction.
2. with granulomatous reaction.

B. Posterior Uveitis

1. chorioretinitis

e.g. toxoplasmosis

2. posterior eye changes secondary to anterior uveal disease.

C. Diffuse Uveitis

e.g. sympathetic ophthalmia

D. Cyclitis, Pars Planitis, Peripheral Chorioretinitis

1. non heterochromic

2. heterochromic

Additional descriptive terms such as acute, subacute, chronic, mild and severe maybe used. At times an unexpected development within the eye during the course of the attack will require that the initial classification be changed. The approach to an etiological diagnosis and treatment is somewhat different depending upon the reaction and the part of the uvea that is involved, so the more exact the initial observations, the better will be the beginning.

I want to limit my discussion to Anterior Uveitis and to describe it as a reaction that may occur, even though the disease is primarily in the posterior eye, or it may occur in non granulomatous or granulomatous character when the disease primarily involves the iris and ciliary body.

Anterior Non Granulomatous Uveitis is our old friend iritis. It is the most common form of uveal inflammation. In an analysis of 474 cases seen in the Uveitis Clinic of the Washington Hospital Center, 328 could be considered anterior non granulomatous uveitis. This means that inflammation of the anterior uvea is two and a half times more common than posterior uveitis.

A typical attack of iridocyclitis is usually unilateral and is ushered in with considerable pain in the eye aggravated by exposure to light. There is a variable amount of ciliary congestion and visual impairment. Early slit lamp examination reveals a congested pupil and an in-

crease in relucency of the beam. Later cells, which are lymphocytes and plasma cells, appear in the anterior chamber and a few white precipitates of varying size will be seen on the posterior surfact of the cornea. The protein content of the aqueous increases sharply and coagulation of the albumin results in a fibrinous exudate within the anterior chamber preventing circulation of the cells. Oedema of the cornea is occasionally present with or without an elevated tension. The iris lustre is lost, the stromal blood vessels may become visible and synechia to the lens may form. The pupil will usually dilate with mydriatic drops, an adrenalin pack or a subconjunctival injection. In a severe attack a hyphema may occur which suggests a viral or a gonococcal etiology. Hypopyon is uncommon except in Behcet's Disease.

A moderate number of cells will be seen in the anterior vitreous as well as an increase in protein. The reaction in the anterior eye may make it impossible to set the vitreous with either slit lamp or ophthalmoscope. If the fundus can be seen it should be carefully and rapidly searched for healed or active areas of chorioretinitis. It is not usually desirable in a painful eye to use the indirect ophthalmoscope or contact lens and slit lamp. Furthermore the response of uncomplicated iritis to treatment is so satisfactory that these instruments may be quite comfortably used in a few days. The fundus examination of each eye including the periphery of the retina should be entirely negative to maintain a diagnosis of iridocyclitis. The initial examination must include, if possible a thorough search of the fundus of each eye. The examination of the posterior eye may easily be made at this time, a few days later the fundus maybe obscured by heavy vitreous opacities. The results of the examination should be recorded and drawings made of any active or healed chorioretinal

Having then diagnosed an acute iridocyclitis is any survey justified? In private practice it is probably a bit premature to order diagnostic tests. In the Washington Hospital Center a Minimum Initial Survey is ordered at the initial visit and the results of the tests will be available when the patient is seen in the Uveitis Clinic.

Minimum Initial Survey

1. Complete blood count

2. Sedimentation rate
3. Urinalysis
4. Chest x-ray
5. Serology for syphilis
6. Fasting blood sugar

The patient is placed on appropriate treatment and asked to return to the uveitis clinic at the proper time. In the special clinic a medical history relevant to uveitis is taken and all the data transferred to the records used in the uveitis clinic. In many instances the attack is under control and recovery is expected. If improvement has not been so marked, yet the attack is still unilateral and no posterior disease and no change to a granulomatous reaction in the anterior eye, local treatment will be continued and the oral administration of steroids is considered. The results of the survey will rule out diabetes, lung disease and the history rules out peptic ulcer so oral steroids may be safely used without further delay.

If improvement is still slow, the survey will be extended to an ear, nose, and throat, dental prostate and pelvic examination.

Fortunately most attacks of acute anterior uveitis with non granulomatous features can be terminated by non specific management without digging deeper into the basic cause than has been outlined. Exceptions, however, are frequently recurring attacks or a steady attack which does not show signs of coming under control.

A further study for etiological factors must then consider a careful Allergy investigation, or the possible relationship of the uveitis to Juvenile Rheumatoid Arthritis, Ankylosing Spondylitis, Gonococcal Arthritis, Gout, or Reiter's Disease.

The failure to find causative organisms in cases of uveitis has led to the consideration that the disease might have an autoimmune basis. Such a consideration may be important when selecting therapy.

Treatment of Anterior Uveitis with non granulomatous features may be summarized in the following manner:

1. Mydriatics
local instillation
subconjunctival
2. Steroids
local instillation
suspension

- solution
- ointment—at bedtime
- subconjunctival
 - depo product
 - solution
- oral
- intramuscular
 - depo product
 - solution
- 3. Salicylates
- 4. Butazolidin
 - especially indicated if uveitis is associated with a rheumatoid disorder.
- 5. Antibiotics
- 6. Antihistamines
- 7. Foreign protein
- 8. Antiautoimmune therapy

Anterior Uveitis with a Granulomatous Reaction

If the character of the anterior eye reaction changes or if a granulomatous uveitis has been suspected from the start, the investigation must become more extensive. There is a clinical and slit lamp difference between a non granulomatous and a granulomatous reaction within the anterior chamber and the following points will help to make the distinction.

1. If ciliary congestion and pain disappear or were never too severe, yet the signs of uveitis continue and the vision remains impaired granulomatous reaction should be suspected.
2. If the disease becomes bilateral granulomatous reaction should be suspected.
3. If the keratic precipitates becomes larger, more numerous and of the mutton fat variety, granulomatous reaction should be suspected.
4. If the protein content of the aqueous diminishes, and the cells become larger and more abundant a granulomatous reaction should be suspected.
5. If precipitates are found on the iris (Busacca nodules) or at its pupillary edge (Koeppe nodules) or in the angle of the anterior chamber granulomatous reaction should be suspected. Precipitates on the cornea or on the iris are of the same importance. They are made up of lymphocytes, plasma cells and later macrophages. The plasma cells become deposited on the

cornea because of the circulation in the anterior chamber and are deposited on the iris when the eye is at rest during sleep. The cells making up mutton fat precipitates are large and heavy and would settle on the aris when the eye is resting.

6. If iris nodules develop granulomatous disease is almost certainly present. An iris nodule, a rare finding, is a focus of lymphocytes and plasma cells within the iris stroma. A precipitate on the iris is not an iris nodule. A precipitate may form and become covered with pigment and remain as a small round elevated mass above the surface of the iris.
7. If firm wide synechia are forming granulomatous reaction should bt suspected.

In spite of the fact that the distinction between these reactions is a rather subtle one, clinically it is useful because a different approach in study and treatment mut be made in granulomatous disease.

The causes of anterior granulomatous uveitis without chorioretinitis are:

1. Sarcoid
2. Tuberculosis
3. Syphylis
4. Bechcet's Syndrome
5. Sympathetic Uveitis
6. Phacotoxic
7. Phacogenic

To provide the data necessary to establish an acceptable relationship between one of the above conditions and the uveitis it is desirable to have an orderly and complete medical history, physical examination and laboratory study.

The special laboratory studies, x-rays, skin tests and biopsics that will support a presumptive diagnosis of these systemic diseases have been published previously.¹

The treatment that is indicated in Granulomatous Anterior Uveitis is both non specific and specific. It may be necessary to employ more than one kind of specific therapy but it is well not to employ more than one at a time. Unfortunately there are cases where treatment seems of no benefit and steady loss of vision goes on. The available specific therapy for each of the related systemic diseases has been published many times.¹

Summary

This paper has covered only anterior uveitis. Mention is made that a reaction in the anterior eye as a result of chorioretinitis can occur which is indistinguishable from anterior uveitis alone. It is desirable therefore to have frequent and careful checks of the posterior eye to rule out chorioretinitis.

This paper points out the clinical picture of

anterior uveitis with non granulomatous features and emphasizes its relationship to allergy, focal infection and rheumatic disorders.

The causes of anterior uveitis with a granulomatous character are listed and the specific and non specific therapy that is available.

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NEW THERAPEUTIC TECHNIQUE

THE TWO MOST CHARACTERISTIC FEATURES in bronchial asthma are bronchospasm and accumulation of mucus in the bronchial tree. Both lead to partial obstruction of bronchi and thus induce expiratory wheezing. Bronchospasm can be promptly relieved by such medication as epinephrine and intravenous aminophyllin. However it is more difficult to induce evacuation of mucus from the bronchial tree. Administration of expectorants and intermittent positive pressure treatment are not always effective. When mucus cannot be expectorated, it becomes thickened and infected. This leads to a chronic asthmatic state. Dryness of the respiratory surfaces renders the mucus more sticky

and adherent to the bronchial walls. In this state the bronchial dilatation brought about by the action of epinephrine and aminophyllin no longer suffices. The patient becomes "epinephrine-fast." The glue-like material behaves like a foreign body caught in the bronchi. It constitutes a check-valve to the portion of the lung distal to it, allowing the air to enter during inspiration, but trapping it during the expiratory phase. Death in asthma is usually due to asphyxiation by obstruction of the bronchi with mucus.

In 1949 the author showed that the bronchoscope which heretofore had been used mainly for diagnostic purposes, can effectively serve as a therapeutic tool by removing the obstructing mucus from the bronchi and thus breaking up asthmatic attacks. The main bronchi can thus be cleared of mucus by aspiration. The distal portions of the bronchial tree likewise benefit indirectly from the procedure: When, following removal of the bronchoscope, the upper air passages are cleared of mucous plugs, spontaneous evacuation of the secondary bronchi takes place through persistent coughing which follows the procedure.

In 127 cases so treated,¹ the most dramatic results were obtained in eight moribund individuals in whom this procedure constituted a life-saving measure. 54 cases received no benefit. Since 1949, more than 1500 patients with allergic asthma have been treated by bronchoscopic lavage. On the basis of this experience, the indications and contraindications for the procedure can be established:

In addition to its employment as a lifesaving procedure, bronchoscopic lavage was utilized in the following situations arising in the management of the asthmatic patient: 1. To break

BRONCHOSCOPIC LAVAGE IN BRONCHIAL ASTHMA

G. L. Waldbott, M.D./detroit, michigan

up a chronic asthmatic state. 2. To relieve partial atelectasis due to obstruction of a bronchus by a single mucous plug. 3. To evacuate mucus in complicating bronchiectasis. 4. To dilate bronchostrictures, a rare complication of allergic asthma.

Bronchoscopic treatment should not be employed where there is little or no mucous secretion or when the sputum is thin and watery. This applies to asthma of short duration in which edema of the alveoli associated with, or followed by, pneumonitis is frequently encountered;² to incipient asthma characterized by a nonproductive pertussis-like bronchitis, in which bronchoscopy reveals petechial hemorrhages and occasionally urticaria-like edema of the bronchial mucosa;³ to sudden severe attacks (allergic shock) following injection, ingestion or inhalation of an antigen to which extreme sensitivity exists in which bronchospasm and edema of the respiratory mucosa dominates the clinical picture; to asthmatic attacks of psychosomatic origin in which spasticity of the bronchi prevails.

Since the introduction of bronchoscopic lavage in asthma, its efficacy as a lifesaving measure in moribund patients has been demonstrated on many occasions. Yet, some bronchoscopists hesitate to employ this treatment in a dying patient because accidents have been reported due to intolerance or allergy to drugs, especially to narcotics, atropine and local anesthetics.

In order to avoid such experiences, drugs should be used as sparingly as possible. In

cases with marked anoxemia, sufficient drowsiness is present to dispense with anesthesia altogether. If the patient is conscious and a pre-operative sedative does not suffice for adequate relaxation of the patient, a local anesthetic is applied at first to a small test area of the buccal mucosa. This area is observed for about ten minutes. If there is no local allergic reaction, i.e. no unusual excessive edema and hyperemia, the anesthetic can be applied to the pharyngeal wall. A small intravenous injection of aminophyllin (about 2 cc of the 125 mg. ampoule) is administered pre-operatively. 1 to 5 drops of epinephrine are added to the lavaging solution for its bronchodilating effect. The use of penicillin, sulfa and other antibiotics has been abandoned because of the danger of sensitivity to these drugs. Preoperative administration of a narcotic combined with atropine is contraindicated.

The saving of lives and the breaking up of extremely chronic asthma has rendered bronchoscopic lavage one of our most important therapeutic measures. In a moribund asthmatic, bronchoscopic aspiration is as obligatory as the removal of a foreign body from a bronchus or a tracheotomy in diphtheria.

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AN OBJECTIVE REVIEW OF DRUG SAFETY

It behooves us to try to work out some reasonable approach so that the patient can be protected but not be discriminated against because of fears and anxieties in regard to the use of drugs. It seems that we should all support the efforts of establishing a committee of medical scientists independent from both the government and manufacturer to which such matters can be referred for evaluations of safety. In this way the private practice of medicine can function more adequately and feel more comfortable in knowing that the drugs are being reviewed in a more objective manner.—Louis M. Foltz, M.D., in *Journal Kentucky State Medical Association*, 62:10, (Oct.) 1964.

AMERICA'S NUMBER ONE EPIDEMIC

William D. Coleman/buffalo, new york

A PECULIARLY AMERICAN DISEASE, so statistics tell us, is our national and apparently insatiable desire to destroy ourselves in automobile accidents.

As crash deaths and injuries mount, the obvious solution to this mania for self destruction lies in two areas—the driver of the automobile and the machine itself.

Imperative Education

Numerous programs, on national and local levels, are aimed continually at driver education—"Slow down and live" or "The life you save may be your own." It is obvious that driver training and education are imperatives, but as in any attempt to modify human attitudes, the progress is slow. Automobile accident fatalities continue to rise in spite of official and voluntary efforts to turn the tide. We can only speculate at how high the statistics would soar if there were no driver education programs or accident prevention safety campaigns to hold deaths in check.

The other basic approach—concurrent with attempts to solve the human problem—is to the great big shiny machine the peculiarly motivated American uses to hurl himself down highways and byways.

The Measures

What can be done to the automobile itself to make it optimumly safe? What can be done through research and manufacturing skill to protect the driver perhaps against himself, while others are working on his aptitudes and attitudes?

Four Illinois groups, in cooperation with Cornell Aeronautical Laboratory, Inc. of Cornell University, are working on the answers to these questions. The Illinois State Medical Society, the Illinois State Highway Police, the Illinois Hospital Association and the Illinois Department of Public Health are the participating agencies. Norman J. Rose, M.D., Chief, Bureau of Epidemiology (CD) of the Illinois Department of Public Health is serving as medical coordinator of the program.

The initial four-year Automotive Crash Injury Research (A. C. I. R.) study in Illinois ended on March 31, 1964. During this initial study, a concerted effort was made by the cooperating agencies to report on all rural injury-producing accidents involving passenger cars in selected sampling areas of Illinois. With the approval of Illinois agencies an additional four-year study started January 1, 1965, during which only those injury-producing accidents in selected areas that involve passenger cars of the last five year models will be studied. As is the first study, the limited study is to be conducted in the sixteen State Police districts for a six-month period as indicated:

Period	Area	Dates	Year Model Cars
1	Dist. 6 & 8	1/1/65- 6/30/65	61-62-63-64-65
2	Dist. 5 & 11	7/1/65-12/31/65	62-63-64-65-66
3	Dist. 2a & 13	1/1/66- 6/30/66	62-63-64-65-66
4	Dist. 12 & 14	7/1/66-12/31/66	63-64-65-66-67
5	Dist. 4 & 11a	1/1/67- 6/30/67	63-64-65-66-67
6	Dist. 7 & 10	7/1/67-12/31/67	64-65-66-67-68
7	Dist. 1 & 9	1/1/68- 6/30/68	64-65-66-67-68
8	Dist. 2 & 13a	7/1/68-12/31/68	65-66-67-68-69

These are Illinois State Police district area headquarters and serve as field coordination points for the eight field studies. Only specified accidents investigated by the Illinois State Police are within the scope of the study.

The A. C. I. R. project in Illinois, to determine how automotive design can contribute to passenger safety, will succeed or fail based on reports supplied by Illinois Physicians and State Troopers.

In Detail

The information from the Illinois State Police covers in detail the conditions surrounding the accident itself: road design, type of road, surface conditions, number of vehicles involved, estimated speeds, details of external damage to the involved vehicles, objects struck by occupants. Additional information is supplied by State Troopers on interior damage to the automobile, and photographs, when needed, will supplement the written report.

Step two in the chain of field research is the completion of the A. C. I. R. medical report form by the physician attending the accident victim. The form, which takes less than five minutes to complete, is given by the investigating trooper to the attending doctor or to the emer-

gency room supervisor of the hospital to which the accident victim is removed. A separate medical report is submitted for each injured person; stamped self-addressed envelopes are supplied to physicians and hospitals to simplify submission of reports.

Coordination of reports from troopers and physicians is done in Springfield by the State Department of Public Health. The package of field data is transmitted to Cornell Aeronautical Laboratory of Cornell University for intensive study. The physicians' reports are considered privileged medical information.

Will Not Disappear

Information from previous A. C. I. R. studies did not disappear into a statistical lost forest. Many life saving features on the automobiles of 1965 came from these and similar studies. Strengthened door locks, recessed steering wheel posts, padded dash boards and sun visors and, of course, safety belts are life saving devices that might not be on our new cars without field research.

The need is obvious; the goal important and dramatic. For these reasons the Automotive Crash Injury Research program is especially pleased to be commended and supported by the Illinois State Medical Society.

"NOTHING MUST INTERFERE WITH OUR RESEARCH EFFORTS"

The Food and Drug Administration has a job to do and it is doing it well. It must not compromise on safety or fraud. But it must realistically face up to a greater responsibility of encouraging potentially new useful compounds with the same intensity it would seek to discard new harmless and ineffective compounds. Nothing must interfere with our research efforts. In this task the FDA must call upon the assistance of the university scientist, because both possess common long-term goals, both have skills to share, and the talent is too scarce to waste and the problems are too important to work apart. I am confident the leadership is equal to the task and that it will respond.—L. T. Coggeshall, M.D., in *Clinical Research*, 22:3, (Oct.) 1964.

MORTON'S METATARSALGIA is a chronic, painful affection of the foot most frequently thought to be caused by so-called neuromas of the third interdigital nerve. Although there are other common causes for metatarsalgia, such as hypertrophy of the plantar condyles and plantar veruccae in the area of the metatarsal heads, common usage of the term "Morton's disease" has helped to establish this syndrome as a clinical entity. The so-called interdigital neuroma of the foot is a relatively infrequent occurring lesion. T. G. Morton, whose name the disease bears as Morton's disease, referred to the condition as a peculiar and painful affection of the

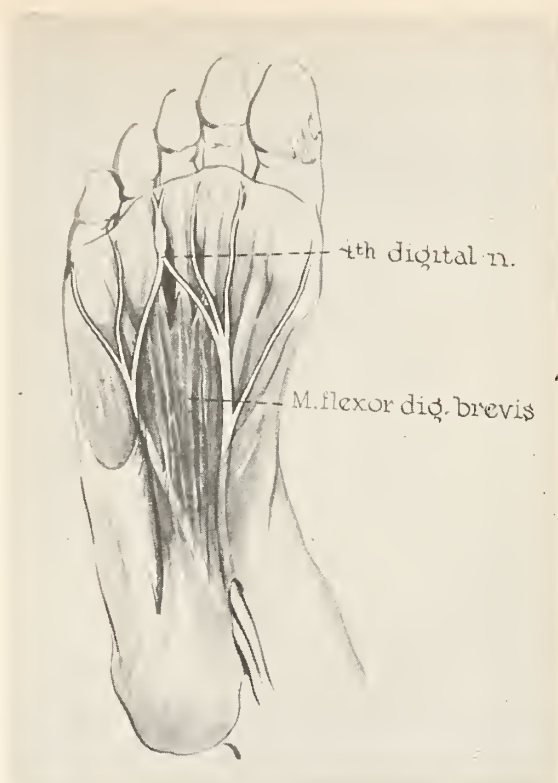


FIGURE 1. Diagram showing dual origin of the fourth digital nerve on either side of the flexor digitorum brevis.

MORTON'S METATARSALGIA: A MISCONCEPTION

Paul F. Nora, M.D., F.A.C.S., Ernest D. Nora,
M.D., Edward Ghislandi, M.D./chicago

From the Department of Surgery, Northwestern University School of Medicine and Columbus Hospital, Chicago, Illinois.

Associate in Surgery, Northwestern University School of Medicine; Chief of Surgical Service, Columbus Hospital, Chicago, Illinois. Deceased.

Resident in Pathology, Columbus Hospital, Chicago, Illinois.

Presented before the Chicago Neurological Society, April 1964.

fourth metatarsal phalangeal joint.

The authors have reviewed the literature on Morton's metatarsalgia. They present evidence found in 42 surgically excised lesions of the foot from 1956 to 1963 plus reports in the literature, which support the idea that this is a clinical diagnosis.

In his first treatise on the subject in 1876, Morton¹ stated that the symptoms of the disease were probably due to compression of the branch of the external plantar nerve on the lateral surface of the fourth toe, between the head of the fifth and the neck of the fourth metatarsus. A concise description of this clinical problem, however, was first given in 1845 by Durlacher,² who was surgical chiropodist to the Queen of England. Owing to the impetus of the work of T. G. Morton and his son, T. S. Morton,³ increased interest developed in this problem.

In 1898, Jones and Tubby⁴ reported on 30 cases of Morton's metatarsalgia, dividing the disease into three types, according to severity of the symptoms. They too, believed that the basic etiology was some form of compression

of the nerves. The standard treatment at that time was resection of the head of the fourth metatarsus. Other early authors related the disease to an abnormal strain on the anterior metatarsal arch. The present authors question whether many of these writers were not referring to other acquired forms of metatarsalgia, rather than a true Morton's disease. Inflammatory changes of the metatarsophalangeal joint, bursae, or ligaments have also been implicated.⁵

The first mention of a neuroma as the underlying pathology was in a report in 1893 by Hoadley.⁶ The concept of a neuroma as the basic lesion, however, did not receive much attention until about 40 years later. A series of 10 patients was reported by Betts,⁷ in which he made histologic examination of all specimens. He claimed that a neuroma was found in all cases, and he advised neurectomy as the treatment of choice. His explanation for the involvement of the digital nerve in the third metatarsal interspace was detailed. The dual origin of this particular digital nerve coming from each side of the belly of the flexor digitorum brevis, and its early division about one centimeter distally, requires a thick fibrous sheath (Fig. 1). This thickened fibrous sheath lies directly on the transverse ligament which is a rigid structure. In attempting to dorsiflex the toe, the flexor brevis contracts, forcing the nerve to stretch over an unyielding ligament, which results in trauma. Changes in the nerve and associated structures are self-perpetuating and help to explain the lack of tendency for natural cure.

Subsequently, McElvenny⁸ reported 12 cases of Morton's disease, five of which on histologic examination were either a neurofibroma or an angioneuroma. In a series of 14 patients, Baker and Kuhn⁹ claimed that their specimens closely resembled amputation neuromas. Reporting on five cases of Morton's disease, King¹⁰ was of the opinion that the surrounding perineural tissues were markedly thickened but that there was also a marked reduction of the nerve fibers. He proposed the term sclerosing neuroma to differentiate this entity from amputation or traumatic neuroma.

After studying 27 patients, Nissen¹¹ was of the opinion that the primary pathology was a vascular lesion with a secondary ischemic neuritis. Tumefactive perineural fibrosis of the

digital nerve of the foot was suggested by Bickel and Dockerty.¹² It was stated by Winkler, and associates,¹³ that the pathologic process of Morton's disease is essentially degenerative in nature, with trauma the most probable cause. By comparing control cases with Morton's disease, Ringertz and Unander-Scharin¹⁴ have shown a relatively similar vascular pattern in both types. This would tend to negate Nissen's thesis, i.e., that ischemia per se is the primary agent with the neural changes as only secondary manifestations.

Nerve enlargements were referred to by Mulder¹⁵ as neuroma, and he concurred with Morton,¹ except that he believed an involvement between the third and fourth metatarsus the most common location. He claimed also, that the artery is usually with the nerve bundles and would be subject to the same trauma. It was demonstrated by Nissen¹⁶ that in early cases, the involvement is primarily vascular, while in those patients with prolonged duration of symptoms, the neural changes are more manifest. Reviewing 17 cases of Morton's disease, Scotti¹⁷ stated that perineural fibrosis, endarteritis and degenerative changes in the nerves were the most common findings.

Etiology and Pathogenesis

Trauma per se is considered the basic mechanism of Morton's disease. The manner in which it occurs, however, and the type of resultant changes, have been the subject of much discussion. The relatively high incidence of the disease in the female, indicates that footwear plays an important role. The disease appears to be on the increase, due to the development of more restrictive footwear for women, suggesting that the individual's anatomy is a most important factor. The previously mentioned concept by Betts⁷ of the action of the flexor digitorum brevis which is anchored on each side by a contributing branch to the third digital nerve, must be considered. Assuming that this is a factor, the changes in the perineural tissues are much more extensive than the changes in the nerve itself. Associated vascular changes are probably the result of the same trauma.

The resultant changes that do occur, do not appear to be true of perineural fibrosis and an



FIGURE 2. Plantar view showing appearance of feet with acquired metatarsalgia. Note callosities under metatarsal heads.

associated endarteritis, except for a few cases that resemble an amputation neuroma. The pathology encountered resembles neither that of a neoplasm nor a true neuroma.

Diagnosis and Differential Diagnosis

Morton's disease is one of the least common of the metatarsalgias. Early signs of *Pes transversus* are loss of the metatarsal concavity and thickening, with redness and tenderness of the skin.¹⁸ As the disease progresses, large bursae frequently develop under the metatarsal heads (Fig. 2). Eventually, the patient may develop clawing of the toes. This entire picture is in sharp contrast to the usual Morton's disease with a relatively normal metatarsal arch and a usually normal appearing plantar surface of the foot. This condition should be differentiated from *Pes transversus*, although the terminology, weakened metatarsal arch or even metatarsal arch may be a misnomer.

In most patients with *Pes transversus*, therapeutic trial with conservative manage-

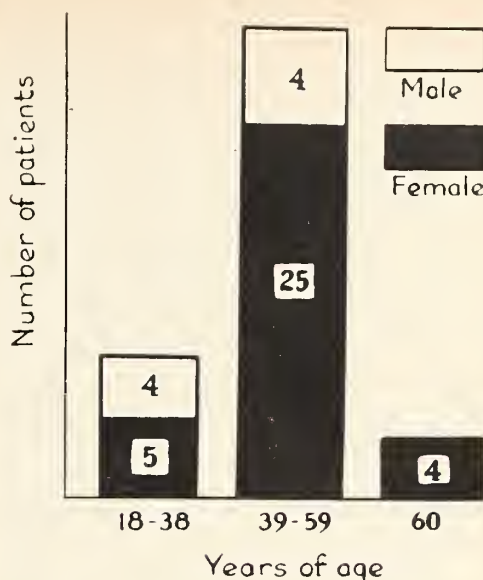


FIGURE 3. Bar graph showing both sex and age incidence of series.

ment is a good regimen. This will tend to exclude those patients who do not respond to conservative treatment and indicate the presence of Morton's metatarsalgia.

Treatment

In true Morton's disease, operation is the only therapeutic method that has rendered permanent relief in the authors' series. Injection of hydrocortisone acetate into the metatarsal interspace involved has been described as a substitute for operation. This method has been suitable for obtaining temporary relief. The present authors realize that this is not a consensus but in their experience, surgical excision has been necessary, regardless of previous therapy.

Material for Study

Clinical Data: A total of 43 patients with Morton's disease were treated by the authors, 32 of whom were women; a ratio of three to one compared to men. The ages varied from 18 to 66, over 80 per cent being between 40 and 65 years of age (Fig. 3). Duration of symptoms varied from two months to seven years. The average time interval from the onset of symptoms to operation was one year.

Symptoms and Subjective Findings: All pa-

tients in the series had symptoms such as, paroxysms of a burning, lancinating type of pain. In 39 of the 42 patients the pain was most severe in the region of the third metatarsal interspace, radiating to the opposing surface of the third and fourth toes; in two the most severe pain was in the second metatarsal interspace; and in one the maximum intensity of pain was in the fifth metatarsal interspace. All patients treated had unilateral involvement. Most of the patients claimed that the pain was most severe when walking. In approximately one out of seven patients the attacks of pain began during complete rest.

Objective Findings: Tenderness could be elicited in all patients in the study. In over 75 per cent tenderness could be found by deep pressure on the dorsum of the foot just distal to the third and fourth metatarsal heads. Lateral pressure on heads of the metatarsus caused pain in about 10 per cent of the patients. A mass could be palpated in only two patients. The diagnostic test described by Mulder,¹⁵ an audible click on lateral compression of the foot, was detected in six patients. Paresthesia was evident in three patients, but this was not evaluated in earlier cases. The main value of roentgenograms in such cases is in eliminating other diagnostic problems.

Operative Technic: In the series the authors employed and found satisfactory a technic of operation advocated by McElvenny,⁸ and McKeever.¹⁰ A simple neurectomy was performed, under general anesthesia and tourniquet, after evaluation of the peripheral vascular circulation. The procedure consisted of a dorsal skin incision extending from the distal third of the metatarsal shaft to the web space over the specific nerve involved. The interspace was opened by separating metatarsal bones with a self-retaining retractor. Plantar pressure was applied which aided in identifying the specific nerve. The distal end of the nerve was detached and retracted proximally to a point where the nerve passes under the metatarsal shaft. The nerve was transected at this point and excised in toto. Retractor was removed and subcutaneous tissue closed with No. 4 000 catgut and the skin closed with No. 4 0 silk interrupted sutures. Pressure dressings were applied and the tourniquet released. This type of wound heals

readily with minimal problems, compared with a plantar incision.

Results

Results from operative therapy in the series were excellent. Patients were ambulatory the first day postoperatively. Average hospital stay was five days. Most patients have been followed for approximately one year. Of the 42 patients operated on, 35 are completely asymptomatic since operation. In five other patients a definite improvement was seen initially. Increased function of the involved foot was noted. In these five patients pain was absent immediately postoperatively. Subsequently, there was some return of the burning sensation but with much less severity and frequency. In the remaining two patients, there was no objective or subjective improvement. Convalescence was from one to three months.

Pathology

Gross findings were usually a yellowish-white fusiform mass that bulged out of the interspace on plantar pressure. Careful dissection showed a white fibrous connective tissue encasing the digital nerve. The nerve itself was not necessarily enlarged, and in most patients did not resemble a traumatic neuroma. In five patients the nerve had a rounded bulb-like appearance, similar to an amputation neuroma. The digital vessel was frequently embedded in this fusiform mass, the location of which varied from junctional or distal to the bifurcation of the digital nerve.

Histologically, the most constant finding was the abundant proliferation of perineural connective tissue. This proliferation extended around the main nerve and between its branches. Changes in the nerve fibers were much more varied. The majority of the specimens showed no increase in the number of nerve fibers.

Comment

Interpretation of a detailed study of the majority of cases in our series, strongly suggested some form of irritative perineural fibrosis, rather than a true neuroma or neoplasm. Nevertheless, because of the absence of a clear-

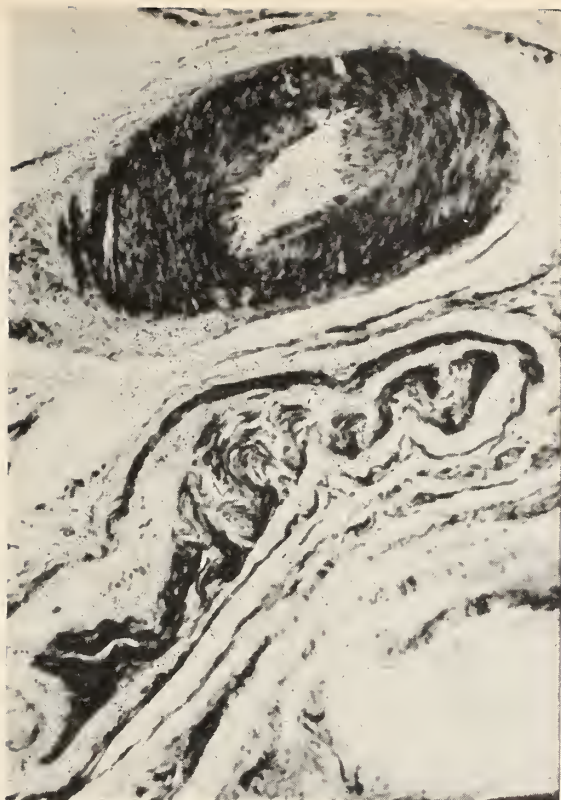


FIGURE 4a. Histologic section of a surgical specimen of so-called neuroma. Evidence of marked vascular changes in associated vessels is seen but only minimal changes in either nerve or perineural connective tissue can be demonstrated.



FIGURE 4b. Histologic section of specimen of nerve removed at autopsy for control series. A marked thickening of perineural connective tissue and increase in number of nerve fibers is illustrated.

cut histologic and pathologic picture of this clinical entity, we performed a control study. We examined digital nerves of the feet of 10 autopsy patients of similar age, who had died from unrelated causes, with no history of symptoms of the foot. Examination of these specimens grossly, was not enlightening. Histologic examination of these tissues, however, revealed changes in varying degrees nearly identical to those found in the so-called neuromas (Figs. 4 a and b). In some instances the specimen from the control case resembled a true neuroma more than the nerve excised from a symptomatic patient. See Figs. 4 a and b.

Multiple staining technics were employed on all specimens, both control and surgical, such as, silver trichome, periodic acid Schiff stain, myelin stain, and hematoxylin-eosin, to pinpoint the characteristic changes which occur, i.e., the number of nerve fibers, changes in fibrous con-

nective tissue, and thickening of blood vessels. The vascular component, as evidenced by marked intimal thickening, was usually present in all cases. Changes in nerve fibers, perineural fibrosis and vascular changes in the control studies, were comparable in the surgical specimens.

From our material and the literature, we reaffirm the opinion that Morton's disease is not a histologic and pathologic entity. Although we would concede that a definite clinical entity commonly known as Morton's disease does exist, there is no well delineated histologic pattern that can distinguish it from that of the normal foot.

Finally, it bears repeating, that the variance of opinion regarding the title of the disease in question, such as neuroma, ischemic neuritis, irritative and/or tumefactive perineural fibrosis, has reaffirmed the confusion that has pre-existed.

Summary

So-called neuroma of the foot, identified clinically as Morton's metatarsalgia, is discussed.

A review of the literature is presented, to-

gether with the results in a series of patients operated on by the authors for interdigital neuroma of the foot. Evidence in the literature and found in the series helps to support the thesis that Morton's disease is only a clinical entity.

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DEATH BY DEFAULT

The public must be protected of course, but isn't there such a thing as over-protection? Certainly it is no problem to prevent the introduction of any drugs with potentially harmful or mildly harmful side-effects. It's simple—just don't develop any new drugs, or at least make it very difficult for a new drug to be tested and/or marketed. The only difficulty here is that many lives and the improved health of many others would be lost by default, that is, drugs that could be of benefit would never be developed. This is just as wrong as allowing anything and everything to be pushed onto the drug market. For the non-medically orientated it is quite easy to understand the sad results of a thalidomide deformed baby but far less easy for many to comprehend the equally sad results of those lives that can be lost by default.—Joseph P. Schaefer, M.D., in *New Physician*, 13:10, (Oct.) 1964.

EMERGENCY TREATMENT OF CHEMICAL INJURIES

Eduard F. Poser, M.D./chicago

WHEN A CONCENTRATED ACIDIC or basic chemical contacts living tissue it must be quickly neutralized or removed by lavage to prevent serious injury. However, there are areas of the body where anatomical characteristics make adequate lavage exceedingly difficult. One such area is the eye and another is the nose and throat. Irrigation with a buffer is preferable especially in vital areas because of the added protection of neutralization.

A comparison between buffered and ordinary irrigative solutions such as water and normal saline must be made on animals. This necessitates anaesthetizing them and then applying a measured quantity of the destructive chemical to identical areas of tissue, followed at an equal time interval by similar amounts of the other solutions to be compared. Their efficiency in protecting the tissue may be judged by the time required for healing as well as by other objective differences.

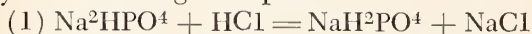
A higher percentage of injury occurs to ocular tissue in proportion to its area than to that of other parts of the body. This is due to the reflex that turns the head and the eyes in the direction of danger for the purpose of evaluating and evading it. Injury to the eyes also produces a protection reflex that causes the

lids to close tightly. This is called the closure reflex or spasm and is due to a violent contraction of the orbicularis muscle. This spasm can make adequate lavage of the globe and the conjunctival sac extremely difficult or even impossible. If immediate lavage is insufficient to wash off the chemical, excessive tearing offers but little protection to the tissue because tears contain such a small amount of solids and salts. They are an aqueous isotonic solution of sodium chloride and bicarbonate at a pH of approximately 7.4 and merely serve to dilute the destructive chemical. Furthermore, drainage of the destructive chemical into the tear ducts and sac may cause great injury to those structures and thus give rise to added complications.

Because of the factors mentioned above, the best emergency treatment solution is that which is harmless to the tissue and which will neutralize even in small amounts either acids or alkalis. Therefore several drops of such a solution may be sufficient to save tissue from irreparable damage should adequate lavage be impossible. A hypertonic buffer is the only one that meets these essential requirements. Lavage with such a solution not only removes the surface chemical by irrigation and neutralization but also causes an outward flow of fluid from the tissue because of its hypertonicity. This tends to inhibit further penetration of the destructive chemical into the tissue.

The buffer described causes no injury to corneal tissue. This was proven by having a subject with a blind eye but a normal cornea drop two drops into his eye daily for one year. This was also demonstrated following experimental treatment of acid and alkali burns produced on anaesthetized rabbit corneal tissue. (Exp. 1 & 2). The hypertonic solution mentioned was made from monobasic potassium

phosphate (KH_2PO_4) and dibasic sodium phosphate ($\text{Na}_2\text{HPO}_4 \cdot 12\text{H}_2\text{O}$). The concentration of this solution was prepared 0.5 molar with respect to the phosphate. These substances are physiologically occurring compounds and do not injure tissue in a high concentration. Moreover such a concentration is essential for quick neutralization, especially when ocular tissue is concerned. The chemical reactions involved in this neutralization process can be demonstrated by the following examples:

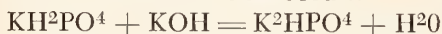


It is evident from these formulae that both the acid and the alkali have been converted into harmless salts. It is also apparent that the hydrogen ion concentration has been maintained at the physiological level.

A buffer solution is one to which an acid or an alkali may be added without much change in pH. In other words it prevents large variations in the hydrogen ion concentration. When hydrochloric acid is added to disodium hydrogen phosphate the following reaction takes place:



The Na_2HPO_4 is slightly alkaline, the NaH_2PO_4 is slightly acid and the NaCl is neutral. The pH change is very small. Thus the addition of a strong acid to a solution such as Na_2HPO_4 which is only slightly alkaline results in an almost neutral solution. Likewise when a strong alkali is added to monobasic potassium phosphate a similar reaction occurs.



The KH_2PO_4 is slightly acid, the K_2HPO_4 is slightly alkaline and the water is neutral. Thus again the addition of a strong alkali to a solution such as KH_2PO_4 which is only slightly acid results in an almost neutral solution. Na_2HPO_4 and KH_2PO_4 together is a buffer which occurs in the body.

Various other solutions formerly used for emergency treatment such as 5% acetic acid, which has a pH of about 2 or 5% sodium bi-

carbonate, which has a pH of about 9 deviate from the biological limits and thus produce harmful effects on delicate tissue. The hydrogen ion concentration of the acetic acid is 100,000 times too high while that of the sodium bicarbonate is 100 times too low. Water and normal saline also used are harmless to tissue but ineffective in small quantities. They merely wash the chemical off the surface providing that no lid spasm occurs. They have no effect on limiting the penetration of the chemical.

The quality and efficiency of the solution to be used for emergency irrigation must be judged on its effectiveness in minute quantities. This is especially important when copious irrigation is impossible. Here speedy therapy is of the utmost importance. Even several drops of the buffer in the conjunctival sac may be sufficient to neutralize the chemical before the lids may be forcibly opened and adequate lavage instituted.

In summary, the ideal solution for eye lavage in the emergency treatment of water soluble acid and alkali chemicals must possess the following qualifications:

- (1) It should be effective in small quantities.
- (2) It should be composed of physiologically occurring substances in high concentrations.
- (3) The hydrogen ion concentration should be maintained at the physiological level.
- (4) It should be hypertonic, thus causing an outward flow of fluid from the tissue to limit the penetration of the destructive chemical.

The phosphate solution described here possesses these attributes. Effectiveness in small quantities is especially important not only because of lid spasm but also because much emergency treatment is conducted by those who are unaccustomed to emergencies.

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COMMUNITY HEALTH

Because community health problems are essentially medical, the medical profession should maintain the leadership in the provision of these services.

MANY COMPETENT, CONSCIENTIOUS PHYSICIANS, find themselves confused and frustrated when they are faced with a community health problem. Trained to cope with, and take responsibility for, individual health problems, they become lost in the complexities of community health organization. Although well founded in the knowledge of the natural history of disease and skilled in the techniques of treatment of disease, practicing physicians often find it difficult to accept the non-medical leadership of many community health programs. Yet, there is no doubt that the physician was, is, and will continue to be, the keystone in the fight against disease.

It also seems to me, that in spite of a great deal of talk about "positive health," community health programs will continue to be focused on

the eradication, control, and prevention of disease. There is a question, however, whether the physician of the future will be a leader in community health activities, or whether he will be a mere technician on the health team. The future leadership of the medical profession depends on the ability of all physicians, individually, and collectively through their professional organizations, to accept the challenge of community health problems and to formulate effective solutions compatible with current social and technological change.

An understanding of the differences between private medicine and community health practice is essential. Both private (or clinical) medicine and public (or community) health aim at the prevention, control and eradication of disease. The difference is basically one of focus or emphasis.^{1,2} The former is practiced on the individual, and the latter, on the community. Because of differences between the individual and the community as a patient, the tools and skills needed by each type of practice are often different, but the approach is still essentially medical or at least based on sound medical knowledge. Biological problems common to both private medicine and community health underly their objectives.³ Kirkwood⁴ defines community health as being the sum total of the health of all the individuals in the community. He emphasizes, however, that the view of a community health program as a mass attack against an opposing environment has given way to the concept of the communities' concern for the health of the individual, both for his own sake and for that of the group as well. Here, the private physician, the health officer, and the public blend their efforts.

An understanding of existing community health services requires a historical perspective. The interplay over the years of two factors,

DEVELOPMENT OF COMMUNITY HEALTH SERVICES: THE PHYSICIAN'S ROLE

*Leon J. Taubenhaus, M.D.
/brookline, massachusetts*

Deputy Superintendent for Ambulatory Services, Boston City Hospital; Clinical Professor Preventive Medicine, Boston University.

social philosophy and scientific technology, to a large extent determines the characteristics of today's community health services. Both of these factors change so rapidly that they often appear to be exploding or undergoing a revolution.

This point is important because it contributes to the physicians' mistrust and lack of understanding of community health programs. The practice of medicine carries heavy responsibilities and is necessarily conservative. New treatments must be critically evaluated before adoption, lest their final result be detrimental to the patient. The path of medical progress is marked with gravestones of once popular therapeutic measures which were later discarded because of their ultimate disastrous results. Leukemia following radiation of the infant thymus and deformed babies following prenatal thalidomide administration are two examples.

It is no wonder then, that the conservative physician has difficulty adjusting to community health programs which frequently appear to change with social pressures. It would be helpful for the physician to remember, however, that these apparent changes are merely fluctuations and that the direction of change remains constant. It is comparable to many chronic diseases which may have exacerbation and remissions, but whose ultimate course is almost predetermined.

The history of social progress is one of urbanization and of the delegation of individual rights to public authority for more individual security. The really rugged individualist was the early cave-man who lived solely by his own wits. As agricultural skills were developed, he learned to live in groups and share his labors and responsibilities with others. Improved technical developments allowed greater agricultural production and the development of industry and commerce. Man now became more urbanized and specialized and hence became increasingly dependent on his fellow men for food, shelter, and existence. Governments were developed and given the responsibility to maintain order and safety. Armies and police forces were established.

In the field of medicine, rapid progress had also taken place. The early medicine man gave way to the physician as scientific doctrine replaced superstition. Early scientific medicine began with the empirical era.⁵ The focus was on the diagnosis and treatment of symptoms,

such as bleeding for fever, poultices for pain, or ointments for ulcer. About 1850, medicine entered the basic science era. Here, advances in medical knowledge and techniques allowed the practice of medicine to focus on the diagnosis and treatment of disease. This major advance in the method of medical practice was bitterly opposed by the successful practitioners of that day just as subsequent revolutionary advances in medical practice were opposed in their turn.

In about 1900, medicine entered the era of clinical science. Now diagnosis and treatment focused on the patient as a total individual. This, too, was resisted at first by the pathologist, anatomist, and bacteriologist whose supreme position in the medical hierarchy was being threatened. Today, in the latter half of the twentieth century, we are progressing into the public health era where the emphasis is on the diagnosis and treatment of the community. We are all aware of the resistance this new era of medical practice is facing.

Yet, there is no alternative and the public health era will prevail. In each era, as emphasis shifts from symptom, to disease, to individual, to community, health sciences become more complex. Each stage brings more problems that require for solution, greater knowledge and advanced tools and techniques. The era of clinical science, to a large extent, is represented by the form of medical practice common today. It is exemplified by a multiplicity of well-trained, capable, medical specialists, many of whom are primarily oriented to a single organ system, and are reasonably aware of the patient as an individual. When the patient has a disease of one organ system at a time he is well treated. For the young acutely ill patient this is often satisfactory, but for the older chronically ill individual this is not enough.

The successes of clinical medicine and public health in the first half of this century has resulted in a lengthening of the life span and has allowed a large segment of the population a longer period of reproductivity. It has also given mankind the time and ability to develop and often live with multiple chronic illnesses. Thus, today we are faced with an expanding and older population that demands more medical care than current medical resources can supply. The multiple chronic illnesses of the average elderly patient requires the simultane-

ous skills of several types of specialists. The major costs of these chronic illnesses often deplete the individual's resources and he becomes a community responsibility.

The public is becoming medically sophisticated and increasingly aware of its health needs. With the passage of the Social Security Act in 1935, the federal government, for the first time, accepted responsibility for the welfare of individuals. This concept of public responsibility for human welfare has now become an accepted social philosophy. As the public becomes aware of its health needs, it demands and expects that these needs be corrected. Today, official and voluntary community agencies organize health programs which are attempting to meet these needs. If they fail, the government will be given the entire job at the demand of the electorate.

The physician, through his own efforts, and through his professional organizations, should take leadership in the direction of community health programs.⁶⁻¹⁰ If he does not, the responsibility will be given to non-medically directed organizations. It is essential for the survival of organized medicine and beneficial to populace that physicians actively lead, and participate in these community health programs.

There are many ways that the physician can serve community health programs. Often the effort required is not great. One major responsibility of all physicians is to insist that community health programs have competent medical direction. Many years ago the medical profession insisted that the government form health departments as the most practical solution to the epidemic diseases then threatening their communities. Thus the health department became the first medically directed governmental agency. The need for a medical specialist, skilled in the art of disease prevention led to the creation of the American Board of Preventive Medicine.

Because many physicians did not understand governmental health programs and feared the supervision that government might impose, they failed to support local health departments. This weakened the role of the health departments and led to the subsequent loss of medical leadership in the community health field. As Freedman has so clearly described, public demand for community health programs continued and these programs were developed. Frequently,

because they were not medically directed, they led to further fragmentation of health services. It is important for the physician to insist that as future community health programs develop, they should be medically led and supported.

Community health activities usually arise from statistical data which demonstrates their need and often their priority. The collection of adequate data is also essential for the evaluation of any ongoing community health programs. Statistics are dependent on adequate reporting.

It is essential, then, that the practicing physician should conscientiously and promptly supply to the local health agency those reports which it requests. In communicable diseases where reporting is statutory, the medical profession has done poorly. Physicians who have failed to report their active cases of tuberculosis or syphilis must share in the responsibility for the recent increased prevalence of these preventable diseases.

For those chronic diseases, where early detection may lead to prevention or to limitation of disability, community screening programs have been developed. Participation by the practicing physician in all phases of these programs is essential to their success. Physicians should serve on the advisory committees of such programs. They must take responsibility for setting the technical standards and procedures used in the program as well as determining the criteria for referral. They should not disparage the program to the occasional normal patient who was referred. A report of their findings should be sent to the referring agency so that the effectiveness of the screening method may be continually evaluated.

At times the public good requires cooperation between the medical and para-medical professions. This may be a delicate matter, but it can be handled with discretion. For example, a community glaucoma screening program is most effective when the ophthalmologist and optometrist cooperate. Exclusion of the optometrist leads to the exclusion of his patient. In the glaucoma program with which I have been associated, both the ophthalmologists and optometrists cooperate. A significant proportion of patients seen at the clinic had received all their previous eye care from optometrists. As the optometrists are not legally permitted to do tonometry, their patients who have glaucoma

might not otherwise have been detected before blindness occurred. In one oral cancer screening program, conflicts between pathologists and dentists led to the failure of the program. The need of such a program is obvious from the fact that the five-year cure rate for oral cancer could be increased from 35 to 65 percent if the lesions were detected and removed before they reached the size of two centimeters.

Our health department developed an oral cancer screening program designed to train the practicing dentist to screen for oral neoplasms in his own office. Our training course was developed by a committee of pathologists and oral surgeons from both the medical and dental professions. Although the course was designed primarily for dentists, it was of such quality that one well known teaching hospital allowed four of its surgical residents time off to attend it.

The success of a school health program is dependent upon the cooperation and participation of the private physician. Only if the school is kept informed of the physical and emotional limitations of each pupil, can it make the necessary adjustments to assure the handicapped child his maximum educational opportunity. Thus, the physician who fails to notify school authorities of the pertinent limitations of his pupil patient, is doing that patient a disservice. The practicing physician also has the obligation not to give a child an unwarranted school excuse just because the child or parent requests it. The quality of school examination depends on the quality of the examining physicians. Private physicians should not be critical of school health programs when they fail to participate. The physician also has a responsibility, when requested, to participate in the health education programs of the school. He is an expert on the adequacy of the content of health educational materials and he can exert his influence as a consultant, speaker, or parent.

No public agency can conduct an effective immunization program without the support of organized medicine. The occasional refusal of a medical society to accept a public immunization program has done irreparable harm to organized medicine. Medical societies and private physicians have a moral obligation to act aggressively to prevent the spread of communicable disease. Support for and participation in public immunization programs is a responsi-

bility of both organized medicine and the private practitioner.

Health agencies, and particularly, local health departments, are ideally suited to carry out community based health research. Often these research studies reach the private patients of the individual practitioner. The practicing physician should cooperate with all reasonable community health research projects as the information gained may benefit his patient and even the physician himself.

In my community local physicians participated in a five-year streptococcal control study. The health department took throat cultures on suspected streptococcal cases and their families. All these patients were under the care of their private physician. As a result of this study, the health department developed a filter paper culture method that was simple and easy, and allowed the practicing physician an effective rapid culture service. His patients gained more confidence in him because he was able to culture all his cases and base his treatment on fact and not a diagnostic guess. Likewise, in the field of respiratory disease, cooperative research now under way between the health department and practicing physicians may lead to a new role for health departments in assisting the physician to control chronic respiratory diseases.

In addition to health departments, many other types of agencies and institutions are involved in community health programs. The practicing physician should support, cooperate with, and participate in these programs when they are worthy.

Hospitals are gradually moving into the role of a community health agency. Certainly their outpatient services need physician support. Where home-care programs are available, they need the support and participation of the medical profession.

Nursing homes meet the community need of caring for certain categories of chronically ill and aged patients. Too often these institutions are isolated from the main stream of medical care and provide inadequate care.¹¹ Physicians have an obligation to assist in raising the level of care of nursing home patients. A private patient should not be abandoned by the physician just because she has been admitted to a nursing home. The physician should continue

to care for his patient and visit her in the nursing home setting. He should use his prestige, influence, and knowledge to help the nursing home provide the level of care his patient needs. This cannot be done without some supervisory effort on his part.

Community organizations are continuing to plan new health programs for the future. Private physicians should take an active part in their local voluntary health agencies. They should be board members and serve on appropriate committees. Only in this way can there be appropriate medical direction of community health programs.

In addition to the public benefit derived from the physicians' participation in community health services, the medical profession itself also gains. When the physician takes an active leadership role in a community health activity, he maintains for medical professions as a whole, its traditional role of the ultimate authority in health matters. This is essential if one wishes to preserve the practice of medicine as a profession, for it is this quality of leadership in health or medical matters that categorizes the physician as a medical professional rather than a technician.

His participation in community health activities also enables the physician to mobilize the health resources that aid him in practicing better medicine. Many modern advances in rehabilitation, early detection of disease, and health maintenance are only possible through the coordination of the health activities of a large number of community health resources and disciplines.

Home care programs, adequate nursing home facilities, effective visiting nurse programs, and health department screening and detection pro-

grams aid in keeping the patient in the community where the traditional physician-patient relationships may be maintained.

There seems to be no doubt that the survival of the private medical practice depends to a large extent on the public image of the medical man. Participation and progressive leadership in community health activities are important ways for the physician to uphold the public image of his profession.

Conclusion

There is no simple and easy method of providing community health services. Today's community health problems are complex and expensive, and require the coordinated use of all available health resources; both public and private. Because community health problems are essentially medical, the medical profession should maintain the leadership in the provision of community health services.

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PATHOLOGY CORNER

PARTIAL NEPHRECTOMY FOR TUMOR IN A SOLITARY KIDNEY

*Donald Rolnick, M.D., Harvey J. Whitfield,
M.D., J. S. Grove, M.D., Jack F. Saleh, M.D.,
and Gerald L. Kandel, M.D./chicago*

TUMOR IN A SOLITARY KIDNEY offers a challenge to the urologist. Partial nephrectomy in such cases has been reported in the past. In 1961 Smith found seven cases reported in the world literature and added an eighth successful case.

Case Report

A 54-year-old-Negro female was admitted to Michael Reese Hospital on August 21, 1963, with six hour history of intermittent left ureteral colic and gross hematuria associated with fever and chills. There was no history of similar previous episodes. She was a diabetic on 20 units of NPH insulin daily and had been a known hypertensive since 1954. The patient had a hysterectomy for fibroids in 1961. An excretory urogram was not performed at this time. The remainder of the history was non-contributory.

Physical examination revealed a five foot-three inch female who weighed 248 pounds. Her blood pressure was 160/100. There was marked left costovertebral angle tenderness. The remainder of the physical examination was non-contributory from a urologic standpoint.

The admitting diagnosis was left ureteral calculus.

An excretory urogram performed on August 23, 1963, revealed no visualization of either kidney because the blood urea nitrogen was 60 with a creatinine of 5.0. The patient became oliguric. Cystoscopy on August 23,



FIGURE 1. Retrograde left ureteropyelogram shows hydronephrosis and hydroureter with filling defect in lower ureter. Filling defect was thought to be blood clots around a calculus or a primary ureteral tumor. Tumor of kidney was not diagnosed at this time. Distortion of calyces was thought to be due to incomplete filling with contrast medium.

1963, revealed numerous clots in the bladder with edema around the left ureteral orifice. A right ureteral orifice was not seen. Left retrograde pyelogram was performed (Fig. 1). The patient became anuric shortly after this examination. Repeat cystoscopy and attempted left ureteral catheterization were performed on August 24, 1963. At this time the left ureteral orifice was not located because of marked edema in this area. Again a right ureteral orifice was not seen. Radioactive renograms on August 23, 1963, and August 24, 1963, revealed a nephrectomy pattern on the right and an obstructive pattern on the left (Fig. 2).

Since the patient was anuric it was decided to perform an emergency nephrostomy on August 24, 1963. At the time of surgery she had a fever of 101.0 degrees, blood pressure was 180/120, blood glucose was 306, and the blood urea nitrogen was 63 with a creatinine of 8.7. Upon exposing the kidney through a flank incision a large tumor occupying the lower one-half to two-thirds of the kidney was discovered. Since it was not known if the patient had a right kidney it was decided to perform a partial nephrectomy. Approximately two-thirds of the kidney was removed. A portion of upper ureter and renal pelvis were removed with the tumor. The renal pedicle was clamped for 30-40 minutes. Twenty-five grams of mannitol was

From the Departments of Urology, Michael Reese Hospital and The Chicago Medical School, Chicago, Illinois.

Read at clinical meeting of Chicago Urological Society, Michael Reese Hospital, February 5, 1964.

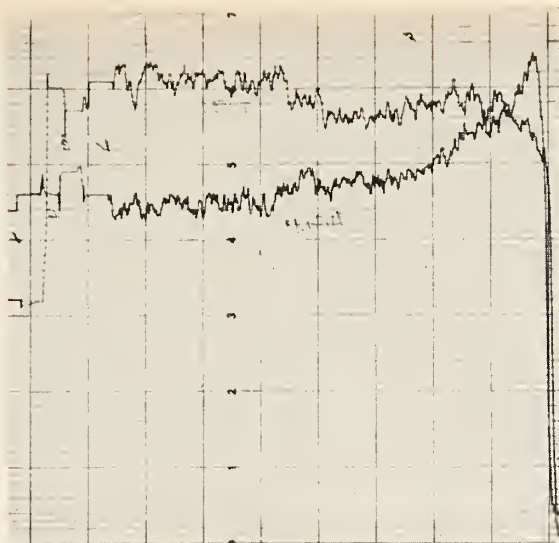


FIGURE 2. Radioactive renogram shows obstructive pattern on left with nephrectomy pattern on right.

given during surgery. After removing the pedicle clamp massive venous bleeding occurred which was thought to be from the renal vein or ovarian vein. It was necessary to leave a five yard pack in place to control the bleeding. A nephrostomy tube was inserted into the remaining renal tissue. Microscopic sections of the tumor revealed hypernephroma (Fig. 3).

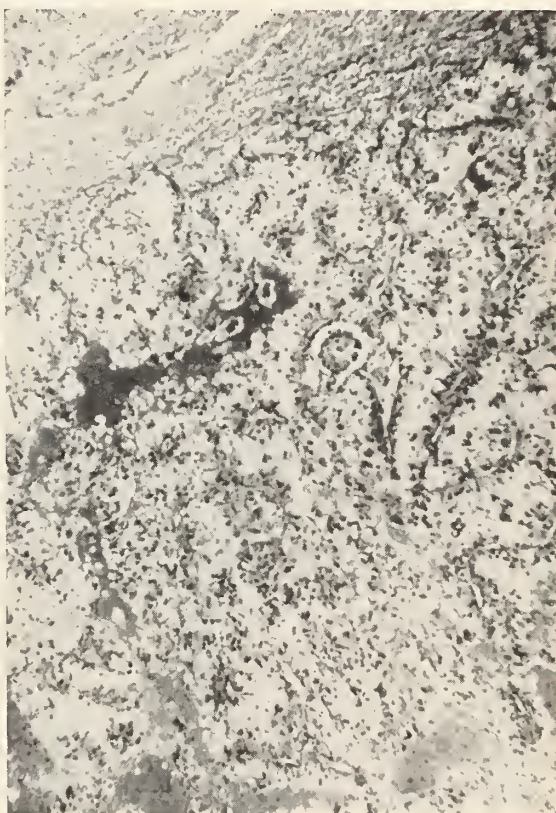
She had a stormy postoperative course. She remained in the Intensive Care Unit from August 24, 1963, through October 7, 1963. During this time she received three peritoneal dialyses. The five yard pack was removed on the eleventh post-operative day. Mention of a few laboratory tests seems to be in order. Her blood urea nitrogen reached a high of 206 on the seventh postoperative day and a low of 69 on September 28, 1963. Blood glucose was 475 on one occasion. Hemoglobin was 5.1 grams on October 2, 1963. Urinary output varied from anuria to a 24 hour high of 450 c.c.

The nephrostomy never functioned well. As a result a revision of the nephrostomy was performed on October 4, 1963. At this time a small portion of kidney was seen and a stab nephrostomy performed. Biopsy of supposed kidney tissue revealed chronic granulation tissue. Again the nephrostomy functioned poorly, but a week later the patient began to void from the bladder and the nephrostomy opening closed after the catheter accidentally came out.

The patient was transferred from the Intensive Care Unit to an open ward on October 7, 1963, and remained there until her discharge from the hospital on November 11, 1963. During this period her urinary output reached a high of 1,080 c.c.

She was apparently able to take care of herself at home until she was readmitted to the hospital on December 31, 1963. At this time she had a blood urea nitrogen of 172 with a creatinine of 18.6. The patient

FIGURE 3. Microscopic section of tumor reveals hypernephroma.



had a continuous downhill course despite one more peritoneal dialysis and expired on January 18, 1964.

Autopsy revealed agenesis of the right kidney and renal tissue on the left weighing 15 grams. There was

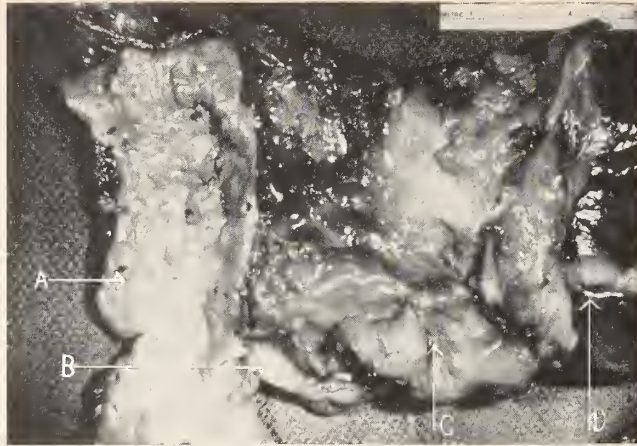


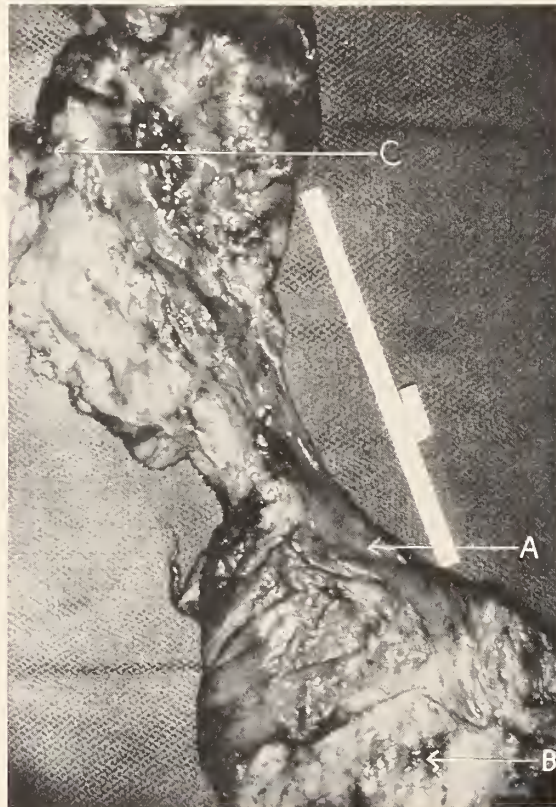
FIGURE 4. Autopsy specimen reveals: A. Aorta with agenesis of right kidney. B. Left renal artery. C. Left kidney tissue weighing 15 grams D. Left perinephric abscess cavity.

a left perinephric abscess with left hydronephrosis and hydroureter (Figs. 4 and 5). There were metastases to the lungs, liver, and spleen. The paraaortic, tracheobronchial, and cervical lymph nodes also revealed metastases.

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FIGURE 5. Autopsy specimen reveals: A. Dilated left ureter. B. Bladder C. Left kidney tissue weighing 15 grams.



MODIFICATION OF THE THOMAS COLLAR

William Newman, M.D./rockford

The greater tendency for spontaneous healing in cervical intervertebral disc injuries, as compared to lumbar lesions, may be attributed to 3 factors. The first is the lesser amount of weight borne by the neck, secondly, there is greater vascularity of cervical structures as compared to the low back. Thirdly, the cervical discs are smaller. Since these structures have no vascularity, they depend on diffusion from the surrounding media for nutrition. With the smaller size, the increased relative surface area makes this more effective.

The greater mobility of the neck would be a factor against this spontaneous healing. It would appear that to encourage healing, we must first of all immobilize it, then take the weight off. The second procedure relieves intradiscal pressure caused by muscle tone.

Because of the relatively great vascularity of the neck, therapeutic measures which produce hyperemia should not be expected to be of much value. Such measures could also be harmful by causing too much exudation of fluids into the tissues. This edema type of fluid in the tissues interferes mechanically with the normal exchange of metabolites. Such measures include hot packs, diathermy and ultra-sound. In the author's opinion, they should be used with great caution in neck injuries.

Felt appears to be the most nearly ideal material with which to make a collar. Because of its softness, it can be worn with comfort at night, as opposed to the commercial plastic collar. It absorbs sweat; therefore, is less irritating to the skin. Because it is easily cut to fit the individual, it can be made to fit closely under the mandible and occiput and in this way exert a constant slight traction on the head. Finally felt is cheap and available; the collar takes about 20 minutes to make.

The only disadvantage of a felt collar is that

it cannot be washed, and eventually must be replaced by a new one if worn for several weeks. Because of its absorbant quality, however, this is less of a disadvantage than it may seem.

The collar is cut from $\frac{1}{2}$ inch white felt of good quality. It may be obtained in quantities from the Western Felt Works in Chicago. It is made higher in back than in front to exert greater traction on the posterior portions of the discs. It is bevelled under the chin so that it will not press on the prominence of the thyroid cartilage; this gives a feeling of constriction. Slight indentations are cut over the clavicles to prevent rubbing. It helps to outline the rough design with a pencil before cutting. The knife must be sharp, and after the initial cut, it may be completed with a heavy scissors.

After the felt has been trimmed and adjusted by trying it on the patient's neck, it is ready to be placed inside a piece of $2\frac{1}{2}$ or 3-inch stockinette. At this point, the patient usually will tell you how good it feels. The ends of the stockinette are sewn together, and 6 small holes are made at each end with a #11 scalpel point. Three cords of colored braid are threaded through the holes with a small hemostat or a large needle. Knots are made in the ends of the cords so they will not slip through the holes again. The patient can then tie the cords in a bow in front when he puts the collar on. The reason for 6 holes on each side is so each cord can be woven in and out on each side; in this way the strands will not touch the front of the neck.

Colored braid is obtained in a dry goods store. Using colors makes it easier to identify the 3 cords when tying them.

It is best if the collar is worn constantly except for bathing. No form of immobilization of the neck should be used while driving because it decreases the field of vision.



FIGURE 1. (C.L.) Lateral view of right carotid angiogram demonstrates ICA—internal carotid artery and CS—cavernous sinus.

FISTULAE OF THE CAROTID ARTERY: CAVERNOUS SINUS

*Lawrence Schlachter, M.D. and
Richard Cowen, M.D./chicago*

From the Department of Radiology, Chicago Wesley Memorial Hospital, Northwestern University.

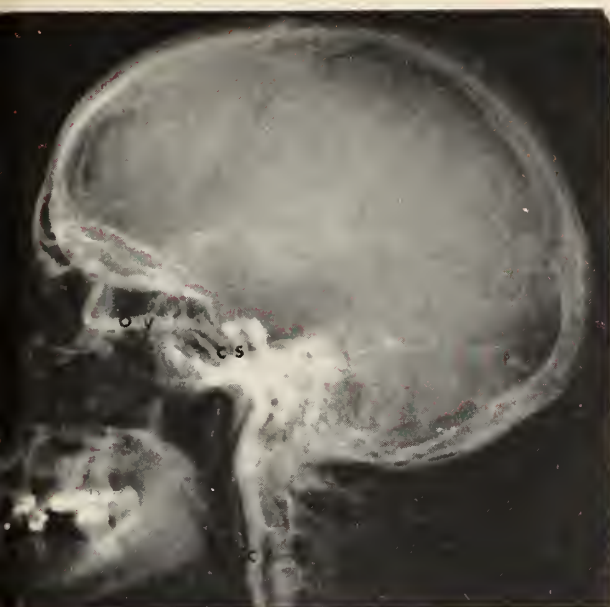


FIGURE 2. (J.B.) Lateral view of right carotid angiogram demonstrates ICA—internal carotid artery, CS—cavernous sinus, and OV—superior ophthalmic vein.

The literature is replete with articles describing the pathological,¹ clinical,² and surgical³ aspects of fistulae between the internal carotid artery and the cavernous sinus, both on a spontaneous and post-traumatic basis. It is the purpose of this article to present a brief and pointed summary of these findings as illustrated by four cases of this entity seen in this institution during the past decade.

Case Reports

Case 1. A fifty-three year old white woman was first seen on 10/13/63 complaining of increasing redness of the left eye. The patient's present illness began spontaneously in July with the onset of reddening and injection of the left eye. At that time she was seen by an ophthalmologist who treated the condition as allergic conjunctivitis. However the injection progressed and in September re-examination demonstrated conjunctival chemosis, increased intra-ocular tension, slight proptosis, and a faint bruit over the left orbit. Angiography was performed at this time and a fistulous communication between the internal carotid artery and cavernous sinus was demonstrated (Figs. 1 & 2). Treatment consisted of ligation of the left internal carotid artery just beyond the bifurcation. The postoperative course was uneventful. There was gradual recession the proptosis, resorption of chemosis, and loss of the ocular bruit.

Case 2: A forty-seven year old white female was first seen on 12/15/52 complaining of pain and swelling of the right eye. The patient's present illness began after

an auto accident in October at when she sustained a skull fracture and injury to the right orbit. Physical examination at the time of admission revealed conjunctival chemosis of the right eye, retinal hemorrhage, papilledema and pulsating proptosis of the right eye with a bruit over the right orbit. Angiography demonstrated the presence of a carotid-cavernous sinus fistula (fig. 3). The patient was treated by ligation of the right common carotid artery. The postoperative course was uneventful with loss of ocular bruit and decrease in the proptosis.

Case 3: A sixty-one year old male truck driver was first seen on 9/4/63 following a crushing injury to his head. The patient had bleeding from the left ear. Physical examination revealed the presence of a right orbital hematoma as well as bilateral abducens ophthalmoplegia. A pneumocephalus without intraventricular air was noted on the skull x-ray. Two days after admission the patient complained of roaring in the left ear, and subsequently developed a peripheral left facial paresis, total left ophthalmoplegia, and a pulsating



FIGURE 3. (C.N.) Lateral view of left carotid angiogram demonstrates ICA—internal carotid artery, CS—cavernous sinus and OV—superior ophthalmic vein.

proptosis of the left eye. At this time a bruit over the left orbit was heard. In the course of the next few days the patient became progressively confused and subdural hematomas were evacuated from both sides. Subsequent angiography demonstrated a carotid-cavernous sinus fistula on the left (Figs. 4 & 5). When the patient's condition became stable a left internal carotid arteriotomy was done with the insertion of a fragment of superficial muscle to occlude the artery. Subsequent angiographic examination demonstrated obliteration of the fistula. Postoperatively there was a gradual improvement in the left ophthalmoplegia with decrease in the proptosis and loss of the orbital bruit.

Case 4: A fifty year old white plant guard was as-

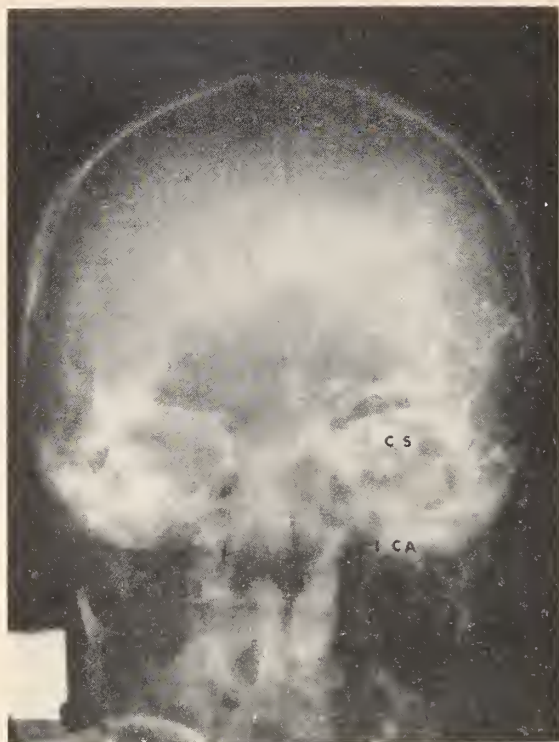


FIGURE 4. (C.N.) Anterior-posterior view of left carotid angiogram demonstrates ICA—internal carotid artery and CS—cavernous sinus.

saulted two weeks prior to admission with trauma to the right orbit resulting in blindness in the right eye. The patient was hospitalized elsewhere and treated with fever therapy. During this time the patient complained of a hammering sensation in his right forehead. Physical examination at the time of his admission to this hospital on 9/23/50 demonstrated a pulsating exophthalmos of the right eye with a bruit heard over the entire right hemicranium. The right common carotid artery was ligated followed by a transient regression of proptosis but the bruit remained. Angiography demonstrated a carotid-cavernous sinus fistula (Figs. 6 & 7). Ligation of the right internal carotid, external carotid, and superior thyroid arteries was done with diminution in the bruit.

Discussion

Traumatic fistulae between the internal carotid artery and the cavernous sinus are more frequently seen in young males. Post-traumatic exophthalmos which is pulsating is presumptive evidence of a carotid artery-cavernous sinus fistula.⁴ Spontaneous fistulae between the internal carotid artery and the cavernous sinus are less frequent and usually occur in older females. Unlike post-traumatic pulsating exophthalmos, spontaneous pulsating exophthalmos must include retro-orbital tumors, and

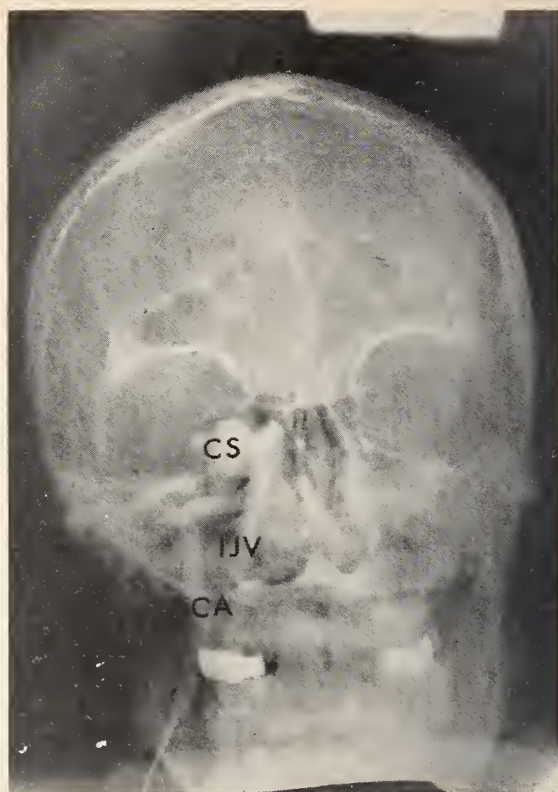


FIGURE 5. (J.S.) Anterior-posterior view of right carotid angiogram demonstrates ICA—internal carotid artery, CS—cavernous sinus and IJV—internal jugular vein.

aneurysms of the ophthalmic artery as differential possibilities.

The syndrome of clinical findings includes conjunctival chemosis, pulsating proptosis, and an ocular bruit as constant features. Homolateral ophthalmoplegias are commonly associated with these fistulae.⁴

Angiographically, the appearance of these fistulae is unique with simultaneous filling of the carotid siphon and the cavernous sinus. Depending upon the size of the fistulous communication, the superficial petrosal sinus and straight sinus may also be filled. The superior ophthalmic vein is constantly filled and its size depends again upon the size of the fistula.

Surgically the lesions have been treated by various approaches—common carotid ligation,² internal carotid ligation,³ ligation of the orbital veins,² and arteriotomy with superficial muscle thrombus.⁶

Resume

Carotid-cavernous sinus fistulae, whether on



FIGURE 6. (J.S.) Lateral view of right carotid angiogram demonstrates ICA—internal carotid artery, CS—cavernous sinus and IJV—internal jugular vein.

a traumatic or spontaneous basis, present clinical findings of pulsating proptosis, conjunctival chemosis, and orbital bruit. Cerebral angiography demonstrates simultaneous filling of the internal carotid siphon and cavernous sinus. Four cases are presented illustrating the clinical and angiographic findings.

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TREATMENT OF HIGH BLOOD PRESSURE

Some advances in treatment have been miraculous. Take for example the treatment of high blood pressure. It is only a few years since there was virtually no treatment at all, apart from general sedation. Then drugs such as the ganglion blocking agents were discovered which could, in some cases, control the blood pressure adequately. But unfortunately the side-effects were troublesome, and patients often preferred to tolerate the disease rather than the depression, visual disturbances, and impotence that went along with the treatment. Gradually these side-effects were eliminated by alteration of formulae, and recently newer drugs have achieved spectacular results.—A. Ian Richardson, M.D., in *Arizona Medicine*, 21:6, (June) 1964, reprinted from the *Manchester* (England) *Guardian Weekly*, March 19, 1964.

NEW PRODUCT STUDY

ENZYME THERAPY OF DENDRITIC KERATITIS

Edward F. Webb, M.D./skokie

sociated with its disease producing potential.⁸ For this reason, I felt desoxyribonuclease might be a potent antiviral agent and—in conjunction with fibrinolysin—act as a debriding agent as well.

The product selected for this study—Elastase®*—was available. I chose it for its stability

DESOXYRIBONUCLEASE-FIBRINOLYSIN (BOVINE) IN THE TREATMENT OF HERPES SIMPLEX CORNEAE AND OTHER OCULAR DISORDERS

THE TREATMENT OF DENDRITIC KERATITIS is more effective and less painful since the introduction of newer methods of therapy. Up until a few years ago, we applied an alcoholic solution of iodine and potassium iodide to destroy the epithelium in herpes simplex corneae and inactivate the causative virus. The solution was effective in many, but it led to a severe local reaction, including pain.

Now, IDU (iodoxuride) and alpha-chymotrypsin are giving better results, with less discomfort to the patient. IDU must be used faithfully and frequently by the patient and this often leaves much to be desired. Topical alpha-chymotrypsin also is of value but it is expensive and has a short working life.

I have read various articles on the use of enzymes via the enteric route or by direct application.¹⁻⁷ This material, plus the inability to control acute viral disorders with conventional methods, made me decide to investigate the effects of topical enzymes. Desoxyribonuclease acid (or DNA analogue) is an integral part of the virus structure, and the portion closely as-

rather than ease of application. A 10 gram tube contains 10 units of fibrinolysin (bovine) and 6,666 units of desoxyribonuclease in a special petrolatum-polyethylene ointment base. Trials on eyes of normal humans and animals showed no evidence of irritation or idiosyncrasy. In dendritic keratitis, the usual dosage was approximately 0.1 Gm. as often as every two hours; and three to six times daily for chemical and thermal burns.

Over a 16-month period, 107 eyes were treated by enzymatic debridement alone or in conjunction with conventional therapy; the results were favorable. This gave me more confidence in the product and I used it exclusively in a variety of corneal disorders (Table I), with the results tabulated as to days of healing. In no patient was healing delayed, nor was it incomplete. Of the 52 cases of dendritic keratitis in the series, 39 were treated with enzymatic debridement alone. Healing was rapid, with little or no cicatrization. Where the lesions were multiple, in general, healing was not as rapid as in the initial case but it was quite satisfactory. Several of the cases had been given steroid therapy elsewhere for "conjunctivitis" and cicatrization seemed more prominent in these patients.

Assistant Clinical Professor Ophthalmology,
Strych School of Medicine, Loyola University.

*Parke, Davis & Co.

TABLE 1.

Case	Age	Date	Diagnosis	Days of RX Before Healing	Other RX	Previous RX
1.	A.L.	11	1/29/62	Deep abrasion, left cornea	2	
2.	H.E.	44	4/2/62	Dendritic keratitis	3	
3.	I.C.	49	4/27/62	Dendritic keratitis	6	I ₂
4.	F.H.	37	9/11/62	Abrasion, left cornea	1	
5.	D.H.	44	10/4/62	3° burn, conjunctiva and cornea	2	
6.	E.D.	63	10/8/62	Dendritic keratitis	4	I ₂
7.	H.K.	46	10/12/62	Severe multiple dendritic	21	IDU
8.	H.F.	50	11/17/62	Severe multiple dendritic	9	I ₂
9.	W.D.	33	11/17/62	Severe multiple dendritic	2	Steroid-1 mo. Steroid-3 wk.
10.	R.M.	29	11/21/62	Abrasion	1	
11.	D.M.	25	11/13/62	Dendritic keratitis	10	Steroid-1 wk. Keratitis marginalis
12.	R.K.	34	3/2/63	S.P.K.	3	
13.	H.F.	21	3/9/63	2° burn, left cornea	1	
14.	J.N.	79	3/12/63	Dendritic keratitis	4	
15.	F.B.	33	3/14/63	Multiple dendritic	10	I ₂
16.	E.F.	37	3/21/63	Dendritic keratitis	3	
17.	S.H.	46	3/22/63	3° limbal burn	2	
18.	M.K.	31	3/23/63	2° burns, left cornea	1	
19.	G.R.	49	3/28/63	Severe dendritic keratitis	20	I ₂ , IDU
20.	R.I.	15	4/1/63	2° burn, right cornea	1	Steroids-1 mo.
21.	T.J.	39	4/1/63	2° chemical burn, cornea and conjunctiva	3	
22.	L.P.	43	4/1/63	Dendritic keratitis	2	
23.	R.L.	20	4/2/63	Abrasion	1	
24.	F.J.	69	4/3/62	Keratitis marginalis, right eye	3	Steroid, tetracycline
25.	O.H.	32	4/5/63	2° thermal burn, left cornea	1	
26.	F.M.	62	4/8/63	Dendritic keratitis & 2° thermal burn	7	I ₂
27.	M.K.	52	4/9/63	Keratitis marginalis	2	Steroid, tetracycline
28.	W.M.	44	4/5/63	2° burn, right cornea	1	
29.	J.M.	18	4/6/63	Abrasion	1	
30.	L.C.	38	4/6/63	3° burn of limbus	2	Removal F.B.
31.	R.M.	42	4/13/63	Keratitis marginalis	3	Steroid, tetracycline
32.	J.C.	23	4/15/63	Multiple abrasions, left cornea	2	
33.	R.B.	47	4/18/63	Chemical burn, right cornea	1	
34.	C.M.	62	4/18/63	Keratitis marginalis	2	Steroid, tetracycline
35.	K.L.	21	4/19/63	S.P.K.	2	
36.	D.B.	54	4/23/63	Dendritic keratitis	4	
37.	J.M.	25	4/23/63	Abrasion	1	
38.	J.P.	23	4/23/63	2° burn, O.D.	1	
39.	N.M.	42	4/25/63	Keratitis marginalis	3	Steroid, tetracycline
40.	F.E.	53	4/26/63	Dendritic keratitis	3	
41.	J.R.	28	4/27/63	Multiple dendritic	3	
42.	H.A.	49	4/29/63	Keratitis marginalis	5	Steroid, tetracycline
43.	B.S.	31	4/29/63	Severe dendritic keratitis	8	
44.	W.M.	44	4/30/62	3° burn	2	
45.	R.C.	15	4/30/63	2° burns, right cornea	1	
46.	F.H.	33	5/2/63	Multiple dendritic keratitis	8	Steroid-1 wk.
47.	M.F.	15	5/7/63	Multiple abrasions	1	
48.	D.D.	21	5/7/63	Epithelium overgrowth following F. B.	2	
49.	G.C.	44	5/7/63	F.B. ulcer	1	
50.	S.S.	40	5/9/63	3° burn, inner canthus	5	
51.	C.W.	23	5/13/63	Dendritic keratitis	5	
52.	W.B.	23	5/13/63	Chemical burn, right cornea	3	
53.	C.W.	23	5/13/63	Dendritic keratitis	3	
54.	J.L.	36	5/13/63	Thermal burn, left cornea	1	
55.	A.L.	25	5/13/63	Traumatic ulcer	2	
56.	D.C.	41	5/16/63	Herpes zoster, conjunctivitis O.D.	3	
57.	J.S.	35	5/16/63	Multiple abrasions O.D.	2	
58.	V.B.	55	5/16/63	Penetrating laceration O.S.	3	
59.	E.C.	20	5/16/63	3° burn conjunctiva, lid, and cornea	20	Surgical debridement
60.	H.S.	51	5/17/63	Keratitis marginalis multiple	7	Steroid, tetracycline
61.	B.S.	31	5/20/63	Dendritic keratitis	4	
62.	S.L.	27	5/20/63	Keratitis marginalis	5	Steroid, tetracycline

TABLE 1. (CONT'D)

Case	Age	Date	Diagnosis	Days of RX		Other RX	Previous RX
				Before	Healing		
63. A.G.	52	5/20/63	Dendritic keratitis O.D.		4		Steroid-3 days
64. J.G.	25	5/22/63	Abrasions O.S.		1		
65. V.B.	55	5/22/63	Laceration, left cornea		4		
66. R.A.	50	5/23/63	Dendritic keratitis		3		Steroid, tetracycline
67. F.S.	40	5/24/63	Keratitis marginalis		2		
68. H.S.	52	5/28/63	Dendritic keratitis O.D.		3		
69. F.D.	34	5/29/63	2° burn and dendritic keratitis O.S.		4		
70. A.R.	52	5/31/63	Macerated penetrating laceration, left cornea		2		
71. F.O.	46	6/14/63	Dendritic keratitis O.D.		1		Failed to use medi- cation of any sort.
72. F.L.	56	6/5/63	Dendritic keratitis O.S.		4		
73. I.C.	49	6/6/63	Dendritic keratitis O.S.		4		
74. C.P.	32	6/6/63	Dendritic keratitis O.S.		4		
75. C.A.	25	8/27/63	Chemical burn of cornea		2		
76. A.M.	28	8/31/63	Herpes Simplex		3		
77. J.N.	33	7/22/63	Herpes Simplex		2		
78. B.S.	37	9/13/63	Herpes Simplex		2		
79. E.W.	61	9/14/63	Abrasion of cornea		3		
80. D.K.	52	9/14/63	Keratitis Marginalis				
81. J.C.	39	9/16/63	E. K. C.		4	Terracortril	1.D.U.
82. H.L.	36	9/19/63	Herpes Simplex		3	1.D.U.	
83. B.M.	4	9/19/63	3° Chemical Burn		2		
84. B.O.	33	9/21/63	Herpes Simplex		4		
85. E.Z.	90	9/27/63	Herpes Simplex		3		
86. H.L.	36	9/18/63	Herpes Simplex		4		
87. E.E.	57	9/30/63	Herpes Simplex		2		
88. H.L.	26	10/6/63	Herpes Simplex		2		
89. R.P.	22	10/7/63	Herpes Simplex		2		
90. R.G.	68	10/16/63	E. K. C.		3		
91. E.M.	40	10/17/63	E. K. C.		5		1.D.U. Phenylephrine Atrophine Trypsin (syst.) Patient used medi- cation occasionally.
92. H.S.	53	10/22/63	Herpes Simplex (severe)		2		
93. R.G.	70	2/29/64	Herpes Simplex, Herpatic Iritis		19		
94. E.W.	46	2/17/64	Herpes Simplex		3		
95. A.Y.	11	3/24/64	Extensive dirty abrasion (snowball)		2		
96. C.D.	59	3/17/64	2° Chemical Burn		1	H ₂ O Lavage	Steroids
97. E.W.	48	3/20/64	Herpes Simplex		1		
98. M.B.	16	4/2/64	Infected superficial laceration		2		
99. J.H.	47	4/3/64	Herpes Simplex		5		
100. P.N.	16	4/7/64	Herpes Simplex		2		
101. D.V.	38	4/9/64	Herpes Simplex		2		
102. W.Y.	51	5/4/64	Herpes Simplex		3	1.D.U.	
103. I.F.	64	5/16/64	Herpes Simplex		5		
104. W.S.	31	5/7/64	Herpes Simplex		2		
105. R.T.	28	5/14/64	2°, 3° Burns		2		
106. M.B.	47	6/22/64	Herpes Simplex		5		
107. H.G.	53	6/25/64	Herpes Simplex		3		

Report of Cases

Case 2. First seen on 3/30/62 with a 3 mm. dendritic figure on the right cornea, just below the mid-pupil. Elase unguent was given, with instruction to apply every two hours while awake. The lesion was completely healed in three days; no staining on fluorescein and slit lamp examination. The faint nebula at the initial site soon faded.

Case 3. First seen on 4/21/62 with an extremely irritable eye and a large dendritic ulcer in the central left cornea. Alcoholic solution of Iodine-KI was used to destroy the epithelium on the initial visit but, three

days later, it was still waterlogged and loose, with an area of 3 mm. missing. Elase was started and, in three days, healing was complete.

Case 7. First seen on 9/21/62, after having been on steroid therapy for "conjunctivitis" for about a month. Numerous dendritic figures occupied the entire corneal surface. IDU solution was started hourly but the response was slow. After 10 days, Elase was used every two hours, in addition to the hourly IDU. Healing was complete in 11 days and the final corrected vision was 20/30, with minimal scarring.

Case 60. First seen on 4/6/63 with a severe thermochemical (hot industrial soap) burn of the right con-

junctiva, cornea, and upper tarsus and overlying conjunctiva. Strands of necrotic conjunctiva were protruding between edematous lids. An estimated 40 per cent of the upper tarsus was avascular and devitalized. After copious lavage, surgical debridement was done and Elase started, to finish debridement. My idea was to clean up the area prior to a mucous membrane graft. This man, without my knowledge or permission, continued working. He reported in to me infrequently but, within three weeks, his wounds had healed and grafting was deemed unnecessary. His cornea had suffered the least possible trauma and no scarring. Some scarring of the upper lid and lower cul de sac occurred, which does not restrict motion but is disfiguring.

Of the 52 patients with dendritic keratitis, seven were known to have had previous steroid therapy. In several other cases, unknown medications had been used, which almost certainly contained a steroid.

In all, 39 cases were handled on Elase alone, usually every two hours while awake. The average duration of the disease in this series was just under four days. In the group in which I₂ and/or IDU was used in addition and prior to Elase, the average rate of morbidity was 11 days. All of these latter cases had received topical steroids previously.

Summary

The author used Elase on 107 unselected cases of corneal damage or disease. In no instance was healing impaired but in keratitis marginalis, little was added by enzymatic debridement. In dendritic keratitis and severe trauma, healing was speeded up and morbidity diminished. This new, potent, inexpensive agent is a good weapon in our battle against certain forms of viral corneal disease.

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1965 CONVENTION SUMMARY

HOUSE OF DELEGATES MEETINGS

Sunday, May 16	4 p.m.
Tuesday, May 18	3 p.m.
Wednesday, May 19	2 p.m.

SCIENTIFIC SESSIONS

Monday, May 17

9 a.m.-5 p.m.	Illinois Society of OB-Gyn.
9 a.m.-10:30	Internal Medicine Panel
9 a.m.-11	Occupational Health
1:30 p.m.	Section on Surgery
	Section on Anesthesiology
	Section on Neurology & Psychology

Tuesday, May 18

8:30 a.m.	Section on Allergy
	Section on Dermatology
	Section on OB-Gyn.
10 a.m.	Illinois Association of Physicians
1:30 p.m.	Section on Radiology
	Section on Physical Medicine
	Section on Public Health

Wednesday, May 19

8:30	Section on Pediatrics
	Section on E.E.N.T. and Pathology
2 p.m.	Camp Lecture (Opens House of Delegates)
3 p.m.	Internal Medicine Panel

LUNCHEONS AND DINNERS

Monday, May 17

Noon	IMT Luncheon
6 p.m.	Public Affairs Dinner

Tuesday, May 18

Noon	Fifty Year Club Luncheon
7 p.m.	Reception and Banquet

Wednesday, May 19

Noon	Illinois Chapter, American Academy of Pediatrics
	Illinois Chapter, American Academy of General Practice

BOARD OF TRUSTEES MEETINGS

Sunday, May 16	Noon
Monday, May 17	8 a.m.
Tuesday, May 18	8 a.m.
Wednesday, May 19	6 p.m.

Exhibits open 11 a.m. Monday, 8:30 Tuesday
and Wednesday; close 5 p.m. daily.

HIGHLIGHTS OF SCIENTIFIC ASSEMBLY

Pediatrics—Wednesday, May 19

I. Pat Bronstein, M.D., University of Illinois

"Spontaneous Resolution of Common Endocrinopathies in Pediatric Practice"

Lewis M. Fraad, M.D., Albert Einstein College of
Medicine

"Can the Busy Pediatrician Contribute to Mental
Health?"

J. A. Myers, M.D., University of Minnesota

"Tuberculosis in Childhood"

Dermatology—Tuesday, May 18

Francis W. Lynch, M.D., University of Minnesota

"Therapy of Skin Carcinoma"

Allergy—Tuesday, May 18

Paul I. Terasaki, Ph.D., U.C.L.A.

"Serotyping of Human Lymphocytes for Kidney
Transplantation"

Armond S. Goldman, M.D., University of Texas

"Milk Hypersensitivity"

Public Health—Tuesday, May 18

Harold M. Erickson, M.D., California Dept. of
Public Health

"Fragmentation of Medical Services"

EENT-Pathology—Wednesday, May 19

Lorenz E. Zimmerman, M.D., Air Force Institute of
Pathology

Charles Iliff, M.D., Baltimore, Md.

"Swelling of the Neck"

John Connely, M.D., Columbia Physicians and
Surgeons

"Tumors of the Orbit"

Anesthesiology—Monday, May 17

Meyer Saklad, M.D., Providence, R.I.

"Pressure Breathing and Respiratory Compliance"

Internal Medicine—Wednesday, May 19

John T. Sharp, M.D., Hines VA Hospital

"Primary Myocardial Disease"

More programs being added . . . watch the
April issue of IMJ for final program plus
annual reports and resolutions.

PHYSICIANS' PLACEMENT

LOOKING FOR A PLACE TO PRACTICE? PHYSICIANS' PLACEMENT CITES OPENINGS

CHAMPAIGN COUNTY

Gifford: population 750. Estimated population of trade area: 3,000. Town without a physician since August 15, 1964. Nearest hospitals in Champaign, 20 miles: Mercy, Burnham and Cole. Office space and housing available. Emergencies admitted to Chanute Air Force Base Hospital, 6 miles. Agricultural area: many residents employed at Chanute AFB and at University of Illinois in Champaign. Churches: Lutheran and Methodist. Nearest Catholic at Penfield, 4 miles. Active Lions Club. Nearest golf courses at Champaign-Urbana. For further information contact: Mr. Arthur F. Busboom, Gifford, Illinois; Walter Rohde, M.D., Fisher, Illinois; Hans Hess, M.D., Rantoul, Illinois; Richard Schaeede, M.D., Rantoul, Illinois.

JACKSON COUNTY

Grand Tower: population 850. Estimated population of trade area: 3600. Town without a physician since February 1964—only physician died. Nearest physicians and hospitals at Carbondale, Murphysboro and Cape Girardeau, Mo., 19, 25, and 30 miles. 92 miles from St. Louis, Mo. No drug store. Office space and housing available. Financial assistance could be arranged. Predominant nationality: English and German. Agricultural community. Churches: Methodist, Baptist, United Presbyterian, Lutheran and Catholic. Bus service to nearest high school at Wolf Lake. Organizations: Lions Club, Masonic Lodge, OES. Good

hunting and fishing facilities. Survey by Sears Roebuck. Foundation indicates community could support a physician well. For further information contact: Mrs. W. B. Lyon, Presbyterian Manse, Grand Tower, Illinois. Phone: 618-565-2682.

LIVINGSTON COUNTY

Dwight: population 3,100. Estimated population of trade area: 15,000. Two practicing physicians, ages 55 and 63. Nearest hospital at Pontiac, 20 miles; 37 miles from Joliet, population 75,000. Local prescription drug store. Ambulance service provided by funeral home. Available office space includes a 6 room office suite, including 2 examining rooms, drug room, waiting room, doctor's office and administrative office on ground floor on Mazon Street and adjacent to free parking area and the business district. Office equipment of former physician for sale. X-ray, etc., about 2½ years old. Housing available. Financial assistance could be arranged. Predominant nationality Danish and Italian. Principal sources of income: VA Hospital, agriculture and coil factory. Churches: Methodist, Congregational, Catholic, Baptist, Lutheran, United Brethren and Nazarene. Grade and high schools. Nearest colleges at Bloomington, 54 miles. Organizations: Rotary, Chamber of Commerce, Lions, American Legion, VFW and DAV, Womens Club, Junior Womens Club; recreational facilities include golf course, village park, etc. For further information contact: Mr. E. W. McPheters, 112 S. Franklin, Dwight (Secretary, Dwight Chamber of Commerce) or A. A. Steiniche, M.D., 107 E. Chippewa, Dwight.

LIVINGSTON COUNTY

Pontiac: population, approximately 10,000. Estimated trade area population, 30,000. Only

7 actively practicing physicians of which 2 are over 65, 3 are between 50-60, and only 2 are between 40-45. Two more doctors on the staff who do almost no practice are over 70. There are no doctors in the area less than 43 years. Two doctors over 50 are apparently taking no new patients. Within five years, it appears likely that there may be only four actively practicing middle aged physicians. Acute shortage of physicians is imminent. St. James Hospital of over 65 beds is located here and is fully accredited and fully equipped with an excellent staff and good supply of nurses and technicians. Patient cost is minimal and lower than the area average for anything similar in accommodations. The community is 35 miles from Bloomington-Normal where two universities of large enrollment exist. 45 miles from Joliet, 60 miles from Peoria, 60+ miles from Kankakee. 1½ hours from Chicago loop and all attendant cultural activities, etc. Three local drugstores with registered pharmacist on duty until late at night. Office space available in numerous buildings in conjunction with other professional offices and some of them offer free rental until the occupant feels he can afford to pay. Several major new sub-divisions currently being developed. New modern apartment building now seeking occupants for rental. Predominant nationality is mixed. Good financially stable community with income derived from 10 or more small industrial plants with three new plants being established. Over 200 retail outlets. Illinois State Penitentiary employs approximately 250 with an inmate population of almost 2,000. Two large new institutions for the aged very recently completed and crowded. Four all new elementary schools and a brand new high school to be opened soon. Organizations: all national service clubs including Jaycees and a very active Chamber of Commerce with local cultural and literary clubs for women. Also a very highly regarded golf course and country club with excellent Elks, Moose, Masonic and Knights of Columbus Lodge. Very large and fully appreciated city supported swimming pool and five city parks. Local art club and Community Concert Association. All citizens of the community are very interested and enthusiastic about acquiring new doctors, whether they be qualified specialists or qualified GPs. Economic stability is perhaps primarily based on the very high

yield local corn crop. All banks are stable and anxious to loan new professional persons any needed finances. Local doctors unanimous in wishing to help new physicians establish a practice in this area. For further information contact: H. C. Parkhill, M.D., Chairman, Medical Procurement Committee, Pontiac, Illinois, or Sister Frances Marie, O.S.F., Administrator, St. James Hospital, Pontiac, Illinois.

MADISON COUNTY

Highland: population, 6,000; estimated population of trade area, 16,000. Three practicing physicians, ages 42, 50 and 51. Three others recently retired or died. St. Joseph's Hospital. 35 miles from St. Louis, Missouri. Three prescription drug stores. 7 room air-conditioned physician's office available. Equipment of a deceased physician available—five years old. Financial assistance could be arranged if desired. Predominant nationality: German and Swiss. Agricultural and industrial community. Churches: Baptist, Methodist, Catholic, Lutheran, Christian Science, Congregational and Evangelical. Grade and high schools. 12 miles to nearest college. Organizations: Optimist, Rotary, Lions, VFW, American Legion, etc. Recreational facilities: 1 golf course and 1 swimming pool. For further information contact: Mr. John Rehkemper, Route 2, Highland, or A. J. Rehberger, D.D.S., Highland.

MARION COUNTY

Iuka: population, 400. Estimated population of trade area: 2,000. No resident physician. Nearest physicians and hospital at Salem, Centralia and Olney, 10 to 30 miles. 80 miles from St. Louis, Missouri. No drug store. Financial assistance could be arranged. Predominant nationality: German and English. Agricultural area. Churches: Baptist, Methodist and Lutheran. 1 grade school; bus service to nearest high school at Salem. Organizations: Eastern Star and Masonic Lodge. Nearest recreational facilities at Salem, 10 miles. For further information contact: Mr. Harold Henne, Box 162, Iuka, Illinois (teacher), or Mrs. Evelyn Howe, L.P.N., Iuka, Illinois.

PIATT COUNTY

Mansfield: population 800. Estimated popula-

tion of trade area: 2,000. Town without a physician for four years. Nearest physicians at Champaign, Farmer City and Bellflower, 20, 6 and 8 miles. Nearest hospital at Monticello, 16 miles. 22 miles from Champaign-Urbana. No drug store. Financial assistance could be arranged. Office facilities available. Agricultural community. Churches: Methodist and Nazarene. Grade and high schools. Organizations: Lions, American Legion, Womens Club, Citizens for Education, Auxiliary, etc. Recreational facilities include: golf, Lake of the Woods (6 miles), Mansfield Park, Hickory Hill Hunt Club; good fishing nearby. New post office. Fine library. For further information contact: Mrs. Genevieve Smith, 107 E. Illinois, Mansfield, Illinois. Phone: 489-2631.

WILL COUNTY

Wilmington: population, 4,450. Estimated

population of trade area: 12,000. Three physicians, ages 40, 50 and 59; fourth physician retired July 1964; need for a replacement. Nearest hospitals at Joliet and Kankakee, 23 miles. Population of Joliet: 77,000. Excellent office facilities. One local drug store. Equipment of retiring physician for sale. 5 grade schools; 1 high school. Churches: Baptist, Catholic, Assembly of God, Church of Christ, Presbyterian, Methodist, Lutheran, Nazarene, Christian and Pentecostal. Organizations: Rotary, Lions, Jaycee, Chamber of Commerce, American Legion and VFW. 75 minutes from Chicago via expressways. Excellent recreational facilities. For further information contact: Mr. L. A. Bittermann Jr., 101 S. Water, Wilmington, Banker, Phone: 476-2351, or Dr. Charles R. Willson, Wilmington, retiring physician.

For up-to-date information in
physician's placement opportunities,
contact Mrs. Jane Swanson,
Illinois State Medical Society
360 North Michigan Avenue,
Chicago, Illinois. Telephone
STate 2-1654

WHAT TO DO WITH SAMPLE DRUGS

Several years ago when the newspapers and magazines were full of news about patients being given experimental drugs without their knowledge, I almost discarded all my samples after several patients looked at me suspiciously and asked what they were being guinea pigs for. . . . Even now I hesitate to give samples to new patients, and when I do, I expressly state, "This is a *free* sample of a drug I have used for years that I happen to have in the office."—Andrew S. Markovits, M.D., in *Physician's Management*, 4:10, (Oct.) 1964.



**PAIN RELIEF
YOU CAN RELY ON**
*comes in minutes...
lasts for hours*

PERCODAN[®]

***in moderate to
moderately severe pain...***

Each scored yellow PERCODAN* Tablet contains 4.50 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

Throughout the wide middle range of pain PERCODAN assures speed, duration, and depth of analgesia by the oral route plus the reliability that counts so much. PERCODAN acts within 5 to 15 minutes...usually provides uninterrupted relief for 6 hours or longer with just 1 tablet...rarely causes constipation.

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of PERCODAN are somewhat less than those

of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also Available:** PERCODAN®-DEMI, each scored pink tablet containing 2.25 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. *U. S. Pats. 2,628,185 and 2,907,768
Literature on request.

ENDO LABORATORIES INC., Garden City, New York

Endo[®]

The View Box

LEON LOVE, M.D.
Director, Diagnostic Radiology
Cook County Hospital

Case 1

This 41-year-old female noticed a progressive swelling of the left palm since age 4, which required eight surgical procedures. It is painful and throbs.

Physical examination reveals a malformed left hand with a non-tender, dusky-colored, raised mass on the palmar surface. A bruit is heard over the brachial artery.



Figure 1



Figure 2

What is your diagnosis?

- 1) Calcified parasites
- 2) Cavernous hemangioma of striated muscle
- 3) Neurofibromatosis with localized gigantism
- 4) Lymphangioma

Case 2

This 25-year-old patient has had a progressive swelling of the left calf over the past 15 years.

Physical examination revealed a warm mass with the skin appearing slightly dusky over the area. The extremity is otherwise normal in size.

(Answer on page 188)

NegGram, a new, oral chemotherapeutic agent, is highly effective against virtually all of the gram-negative organisms which are responsible for 75-80% of urinary tract infections.

NegGram has also produced favorable clinical response in some cases of gram-positive infection despite negative *in vitro* sensitivity.¹ Since it is devoid of any bacterial cross-resistance, NegGram has proved successful in many instances where other agents have failed.^{2,3}

Unlike some drugs, NegGram does not cause neurotoxic or nephrotoxic effects, crystalluria or fungal superinfection and may be prescribed for patients with moderate renal impairment.

**Highly effective
in both acute and chronic
urinary infections**

References: (1) Carroll, G.: *J. Urol.* 90:476, Oct., 1963.
(2) Warren, H. L.: *Missouri Med.* 61:27, Jan., 1964.
(3) Palmer, J. K.: *Week. Urol. Clin. Letter* vol. 6, no. 36, Dec. 24, 1962.

NegGram[®]

Brand of

nalidixic acid

Optimal initial adult dose: Two 500 mg. Caplets[®] four times daily.

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, and mild eosinophilia. Marked overdosage coupled with certain predisposing factors has produced brief convulsions in three patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. Pending further experience, the drug should not be given in the first trimester of pregnancy. Because it is metabolized in the liver and excreted through the kidneys, it must be used cautiously in patients with liver disease or severe impairment of kidney function. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician.

Dosage: Adults: 2-4 Gm. daily by mouth in divided doses. An initial daily dosage of 4 Gm. (2 Caplets of 500 mg. q.i.d.) is recommended for 1-2 weeks. Thereafter, if further treatment is indicated, dosage may be reduced to 2 Gm. daily. Children may be given approximately 25 mg. per pound of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets[®] of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. 250 mg. for children, available in bottles of 56 and 1,000.



Winthrop

Winthrop Laboratories, New York, N. Y.

The View Box

—diagnosis and discussion (Continued from page 186)

Diagnosis: Cavernous hemangioma of striated muscle



Figure 3

In the differential diagnosis of these lesions a typical history of recurrent pain, swelling, and cosmetic change should lead to a presumptive diagnosis of hemangioma.

The presence of phleboliths in any area where there is no venous plexus is pathognomonic of a venous angioma (See Fig. 1 and 4).

Hemangioma may result in regional hypertrophy of bones and soft tissues if the epiphyses have not yet closed. Such local gigantism is related to increase oxygen saturation of the venous blood due to the presence of multiple congenital arteriovenous fistulae in the hemangiomas (See Fig. 2 and 3). The arteries are increased in size, and the venous return is engorged and fills prematurely.



Figure 4

The second most commonly found roentgen finding in cavernous hemangiomas of skeletal muscle is calcification of the tumor, which may be amorphous or appear as grouped curvilinear shadows. Sometimes the lesion looks like a calcified sponge and may be associated with cortical thickening or cortical erosion of adjacent bone.

REFERENCE

Johnson, E. W., Ghormley, R. K. and Dockerty, M. D.: Hemangiomas of Extremities. *Surg. Gyne. and Obst.* 102:531-538, (May), 1956.

Your patients will say
"The Pain Is Gone"
when you prescribe

'EMPIRIN'® COMPOUND
with **CODEINE** gr. 1/2



'EMPIRIN' COMPOUND with CODEINE gr.1/2 (No. 3)
KEEPS THE PROMISE OF PAIN RELIEF



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

EDITORIALS

DILATING OBSTRUCTED ARTERIES

Cine arteriography now makes it possible to diagnose accurately the site and severity of arterial stenoses. Reconstructive surgical operations to increase the flow of blood are performed on the main vessels of the aortic arch, the common and internal carotid arteries, the main renal arteries, the lower aorta and the lower limb arteries. But endarterectomy, angioplasty, and grafting are being done only by highly specialized vascular surgeons.

Dotter and Zudkins¹ are of the opinion that there are too few of these surgeons to cope with the number of patients suffering the painful, disabling, or lethal consequences of the disease. They devised a new transluminal treatment of arteriosclerotic obstruction that can be done by any physician familiar with vascular catheterization. It is a simple technic confined to obstructions in the femoral and popliteal arteries. Best results were obtained in those with short-segment (up to 10 cm.) obstructions of the adductor hiatus.

The procedure is begun with downstream or antegrade femoral catheterization and control arteriography. "An ordinary coil spring catheter guide is passed down the lumen until its tip has traversed the stenosis to reach the lumen beyond. A tapered radiopaque teflon dilating catheter of approximately 0.1 inch OD is then slipped over the guide and advanced until it, too, has traversed the block, thereby

enlarging the pre-existing or newly opened lumen. The guide is passed across the arteromatous block without going through the wall more by the application of judgment than by force; both are often needed to effect the subsequent dilation. Where desirable and possible, a second dilating catheter of nearly 0.2 inch OD is passed over the first."

The University of Oregon radiologists noted striking improvements from modest dilatations in patients with severe, longstanding ischemia. Their experience with 11 extremities was incorporated in a preliminary report. Of these, six have shown marked improvement including four amputations that over averted. No patient was made worse by the procedure. The authors recommend transvascular recanalization in all patients who otherwise would require amputation because of arteriosclerotic ischemia. These individuals have little to lose and much to gain through trial of this experimental procedure. They also believe that the procedure should be used in the treatment of intermittent claudication watching for more serious symptoms to occur or collapsed circulation to develop. Take thrombosis appears to be unlikely in the light of results to date.

T. R. Van Dellen, M.D.

1. Dotter, Charles T., and Zudkins, Melvin P.: Transluminal treatment of arteriosclerotic obstruction. *Circulation* 30:654, 1964.

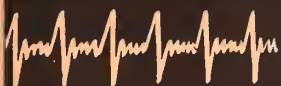
A NEW CONCEPT IN HYPERTENSION

High blood pressure is an important disorder because it may lead to alterations of the most important organs of the body. It causes the heart to enlarge because it must pump against a higher than normal level of pressure. This may eventually lead to disruptions of tissue function and heart failure.

Work was attempted to devise an electronic

device which would effectively lower blood pressure in hypertensive states and maintain it at lower levels. The result was the Baropacer, a compact unit covered with silicone rubber which, including the batteries, is entirely implantable. Each unit is triggered intermittently by R waves picked up by an electrode placed

(Continued on page 199)



PULSE

of the ILLINOIS STATE MEDICAL SOCIETY



A Service of the Public Relations Division

February, 1965

Health Column a Hit with Youth

'Dr. SIMS Talks to Teens' in 375 Schools

ISMS chalked up another "first" in public service programs last month when it introduced a "Dr. SIMS Talks to Teens" health col-

SIMS "approach" to teenage health education that the ISFS project could serve as a prototype for a nationally syndicated AMA teen column, according to Dr. Wallace Wesley, of the AMA's Community Health and Health Education Department.

Prepared and edited by the Public Relations Committee, the Dr.

SIMS column answers questions pertinent to teen health in straightforward, easy-to-understand language. While the principal objective of the feature is to assist school physicians and teachers in providing competent, practical health guidance to teenagers, the column also serves to promote the new corporate symbol of ISMS.



What to do—if acne troubles you.

If you're among the three out of every four teenagers who have to contend with that pesky pimple problem called acne, here are some simple and effective tips for a healthier complexion:

1. Don't get into the habit of picking at or squeezing pimples—you'll only increase the risk of infection. Emptying may sometimes be done by your doctor, but leave it to him.

umn to high school newspapers.

The monthly feature—believed to be the first health column ever offered to schools—was an immediate success as more than 375 public and parochial high schools agreed to publish it on a regular basis.

Another 25 schools, apparently too small to support a newspaper, offered to reproduce and distribute the columns to students, teachers and parents.

The American Medical Association is so impressed with the Dr.

Merck, Sharp & Dohme Gives ISMS Speakers Bureau 'Shot in the Arm'



The ISMS Scientific Speakers Bureau got a shot in the arm from Merck, Sharp & Dohme. J. F. Head, left, district manager of the pharmaceutical firm, presents a check for \$4,000 to Robert L. Richards, society executive administrator, who accepted the grant on behalf of the ISMS Educational and Scientific Foundation. The funds will help pay for honorarium and expenses of physicians who address county medical societies throughout the state. Richards displays the roster of 400 Speakers Bureau members, who this past year offered some 1,400 scientific talks under the auspices of the ISMS Committee on Continuing Education. This marks the second year that Merck, Sharp & Dohme has supported the program.

When Doctors Speak . . . The Public Listens!

ISMS has set a record for the amount of radio and television broadcast time given to its health features and medical news during 1964, announced Dr. Leo P. A. Sweeney, public relations committee chairman.

Total television exposure given to ISMS news or program features—sponsored or produced in part by the society—amounted to 3,097 minutes—or 51 hours and 37 minutes. Broken down, these figures represent two full days, three hours and 37 minutes of television programming throughout the year.

Contributing greatly to this record were the ISMS-produced "Medical Self-Help Training" 16-week series over WTTW, and the ISMS-produced "Medically Speaking" panel show presented for 36 weeks over WCIU-TV. Both were half-hour programs.

The remainder of the television time was comprised of one-minute film and 10-second slide spot announcements on preventive medicine themes, guest appearances of ISMS physicians on various TV shows and annual convention news coverage.

As for radio broadcast time, the new record box score reads like this: 22,787 minutes, or approximately 380 hours—equalling some 16 full days of health and medical information listening.

Mainstays of this radio time are the highly popular ISMS "Medical Interview" show, a five-minute feature produced weekly; and the "Dr. SIMS' Health Tips," 30-second spot announcements aired daily.

These features are broadcast by 55 radio stations throughout the state which regularly subscribe to both series.

Also contributing to the radio broadcast time record were numerous guest appearances of ISMS physicians on a variety of "talk" and interview shows and news coverage of the annual convention.

Citizens in every corner of Illinois are in range to "get the word" and "see the picture" of the Illinois State Medical Society.



This eye-catching promotional kit—proclaiming "When Doctors Speak . . . The Public Listens!"—proved to be a highly effective entree to the offices of busy Illinois radio station executives. The packet contains a record and script of 30 different half-minute health tips from Dr. SIMS and a tape of two five-minute "Medical Interview" shows. The result of this public service promotion is that 55 radio stations throughout the state regularly schedule broadcasts of Dr. SIMS' health tips each day and a different "Medical Interview" program each week. Citizens in every corner of Illinois are in range "to get the word" of the Illinois State Medical Society.

Greene County Medical Society Gives Polio Drive Funds to Schools, Hospitals

The Greene County Medical Society is donating monies collected from its Oral Sabin Polio Vaccine program to hospitals and grade schools in the county, announced Dr. Ludwig Dech, president.

Boyd Memorial Hospital in Carrollton will get \$750; White Hall Community Hospital, \$750; Carrollton Grade School, \$400; Eldred Grade School, \$230; Greenfield Grade School, \$300; Hillview, \$160; Kane, \$175; Patterson, \$160; Roodhouse, \$350; St. John's at Carrollton, \$211; and White Hall, \$350.

The breakdown to the grade schools was based on student population. The Society requested that the grants to the hospitals be used to purchase specific appliances which are needed for patient care and that the grants to the grade schools be used to buy playground equipment.

In letters to recipients of the grants, Dr. Dech wrote that the monetary gifts were made possible by the hundreds of volunteers who so successfully conducted the polio immunization program.

Association of Professions Marks Inaugural



The medical profession is well represented among the slate of officers installed at the first inaugural meeting of the Illinois Association of Professions, which also represents the fields of dentistry, architecture, veterinary medicine, pharmacy, engineering and law. The historic event took place January 28 in Chicago's LaSalle Hotel. Standing solidly behind IAP President Amos M. Pinkerton, Springfield attorney and state bar association executive director, the

medical leaders are Waukegan physician Dr. G. Callahan, board member and first president of IAP; Dr. George F. Lull, board member and past president of the Illinois State Medical Society; and ISMS executive administrator Robert L. Richards, the executive director of IAP. Not pictured is ISMS President Dr. Edward A. Piszczek, elected vice president of the inter-professional group. In the photo at right, Pinkerton pins a diamond IAP emblem to the lapel of Dr.

Callahan as a token of the membership's appreciation of the physician's inspiration and guidance as first president of the organization. Others on the IAP's new slate of officers include engineer C. Dale Greffe of Champaign, president-elect; pharmacist Richard S. Strommen of Chicago, secretary-treasurer; and dentist Dr. Fred N. Bazola, architect Edward J. Walchli of Deerfield and veterinarian Dr. Glenn I. Case of Kewanee, vice-presidents.

Lake County Establishes Scholarship Fund for Health Careers Study

The Lake County Medical Society has established a fund to be used for scholarships in the field of health, announced Dr. Kenneth Morris of Waukegan, president.

The money to start the fund—now containing some \$48,000—came from public contributions to the Sabin Oral Sunday polio vaccine program sponsored by the society earlier this year.

Conference in State Capitol Draws M.D.'s, Legislators

County medical societies throughout Illinois will send delegates to the ISMS Legislative-Public Affairs Conference on Feb. 23 in Springfield.

The agenda includes a tour of the State House in the morning, followed by a luncheon program and conference sessions in the afternoon under the chairmanship of Dr. J. Ernest Breed, ISMS trustee.

The physicians will host a dinner and reception for members of the state legislature.

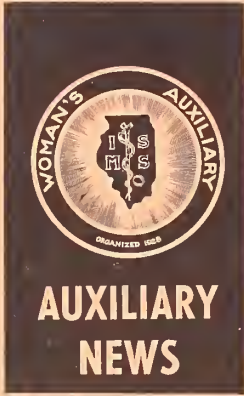
Chicago Health Board Offers Free Measles Vaccine to Physicians

The Chicago Board of Health announces that measles vaccine is currently available without charge to Chicago physicians.

Each package contains 12 doses of live attenuated vaccine, a syringe and 10 cc of gamma globulin.

While the supply lasts, Chicago physicians may obtain packages of the vaccine at the board of health offices, 54 West Hubbard St.

Auxiliary Planners Finalizing Program Arrangements for Annual Convention



EDITOR
Mrs. Oliver
Veneklasen
ASST EDITOR
Mrs. Theodore
Proud

'Grecian Galaxy' Featured at CMS Clinical Parley

A number of special attractions will highlight women's activities at the Chicago Medical Society's clinical conference March 1-4 in Chicago's Palmer House, announces Mrs. P. P. David, general chairman.

Refreshments will be provided for all physicians and their wives in the hospitality room, which will be open for registration from 9:00 a.m. to 4:00 p.m. daily.

A social hour at 11:00 a.m. will precede a noon luncheon on Tuesday, March 2, in the Knickerbocker Hotel. The luncheon—with a "Grecian Galaxy" theme—will be followed by a fashion show and sneak preview of a major movie at the Carnegie Theater. Tickets for this event will be available at the registration desk in the hospitality room.

Featured on Wednesday, March 3, will be a tour of Marina City at 2:00 p.m., followed by a tea at 3:30 p.m. in the building's National Design Center. Convention goers can sign up for this activity at the hospitality room's registration desk. Says Mrs. David:

"All physicians' wives are cordially invited to attend the clinical conference, to renew old friendships and to make new acquaintances."



Arrangements are being finalized by the ISMS Woman's Auxiliary for its 37th annual convention May 17-19 in Chicago's Sherman House. Shown at a recent planning session at the hotel are, from left, Mesdames W. Knaus, publicity chairman; M. Spellberg, convention chairman; J. Koenig, president-elect; Willard Scrivner, president; and E. Szweczyk, installation chairman.



Members of the planning committee for the featured Grecian Galaxy benefit received expert counsel from The Honorable John E. Tsaoussis, Consul-General of Greece. The women beside him at a recent planning session are, from left, Mesdames Paul David, president-elect and clinical conference chairman; Joseph Shanks, publicity chairman; Mitchell Spellberg, president; and Willis Diffenbaugh, standing, ways and means chairman.

Editorials *(Continued from page 190)*

on the heart. Synchronously with each contraction of the heart a train of impulses is released. The intermittent stimuli were found to be more effective than a continuous one.

Baropacers were implanted in dogs with induced neurogenic and renal hypertension and also in those with arteriosclerosis. The carotid sinuses were stimulated by the electrodes; blood pressure was taken of all animals 1 and 2 hours after beginning of stimulation and again after it had ceased. In all cases, a considerable drop in blood pressure was noted after one hour, e.g., from 210/132 to 180/120. Pressure was maintained at about the same level or dropped slightly after 2 hours. One hypertensive dog

was maintained on the Baropacer for 7 days, another for a month.

All animals taken off the Baropacer tended to return to and remain at a lower blood pressure than before the pacing began. Electrical stimulation of dogs with normal blood pressure did not produce as striking a drop as in those with hypertension.

It has been demonstrated that the elevated blood pressure of hypertensive states can be reduced to lower levels and maintained there by the electrical stimulation of the carotid sinus.

T. R. Van Dellen, M.D.

A. M. Bilgutay, R. C. Wingrove, R. L. Simmons, I. J. Dahlstrom, and C. W. Lillehei. *Trans Amer Soc Artif Int Organs* 10:387, 1964.

THE HOUSE CALL

The practice of modern medicine has bypassed the house call because it is time consuming and hospital facilities are more suitable for the care of the seriously ill. Treating everyone in the office and hospital has the advantage of improving patient care and shortening the disability period.

On the other hand, there are many advantages to the treatment of patients at home. The physician obtains firsthand information on how and where the individual lives. The home environment plays an important etiological role in many psychosomatic disorders. The patient may not complain but the cause is obvious the moment the physician enters the door. This is true, especially when the spouse is lazy, messy, overbearing, or incompetent. Poverty or mismanagement may account for weight loss and insecurity. Now and then the patient turns out to be a recluse or the sole supporter of too many in-laws or a vegetating father or mother.

Drs. Richard D. and Joseph R. Wiseman believe in making a house call on every allergy patient. They obtain a better insight into the home environment so as to make practical suggestions on eliminating possible allergens. An asthmatic was sensitive to horse dander yet was

sleeping with a saddle under the bed. In another instance, they found 50 canaries in a room adjoining the bedroom of a feather sensitive, severely asthmatic patient.

A house visit is a must when the allergic individual fails to respond to accepted drugs and suggestions. The family may not be aware of the need for 24-hour precautions. A 13-year-old asthmatic girl slept in a second floor room on foam pillows and a foam mattress. Her mother thought that she had installed all the proper types of dust precautions but usually put several stuffed pillows and animals on the bed during the day. All of these contained well known allergens and would have escaped detection except for the house visit.

These New York allergists find that a few minutes in the home uncover more information than an hour of history taking in the office.

Many elderly people also prefer to remain at home when ill. In addition, the home care of those in moderate financial circumstances saves considerable money. Many youngsters have gone through college on the money saved by treating a father with a fatal disease at home.

T. R. Van Dellen, M.D.

1. Wiseman, R. D. and Wiseman, J. R., Value of Home Visits in the Treatment of the Allergic Patient, *New York State J. Medicine* 64:1948 (August 1) 1964



Rx Reviews

and New Products

GLASSWARE WASHER



The newest addition to the product line of Heinicke Instruments Co. is the unique Hei-Thermo Jet, combination glassware washer/dryer. Covered by six basic patents, the fully automatic Hei-Thermo-Jet offers washings, rinsing and drying in one efficient unit 42" wide, 48" deep and 62" high.

Cleaning is accomplished by the impingement of pulsing jet streams on the glassware while the jet system moves back and forth over the glassware. The pulsations in the jet streams are created by the patented Heinicke Heipulser, a metal reed which has the same effect on liquid flow as a clarinet reed has on air flow. By pulsing the liquid stream to a frequency of 20,000 to 30,000 cps, the contamination and the

glassware are made to vibrate at different frequencies, causing the contamination to be loosened and flushed away.

A new 4-cycle timer control unit permits completely automatic and adjustable control of each cycle by the operator. The flow and volume of air, as well as the temperature of the air forced through the chamber during the drying cycle are automatically controlled and adjustable up to 250° F. by the operator.

The new Heinicke Hei-Thermo-Jet combination washer/dryer incorporates all the famous patented principles of operation plus the new, highly efficient drying cycle and guarantees your operations the ultimate in efficiency.

Non-Thiazide Diuretic

A non-thiazide oral diuretic which may be an important contribution to diuretic therapy is now available from Smith Kline & French Laboratories.

The new drug is 'Dyrenium' (brand of triamterene), a new chemical entity and SK&F's first diuretic product. Indicated for edema from widely varying causes, 'Dyrenium' is effective in many patients resistant to other diuretics and is useful with other diuretics to potentiate their effect and does not cause potassium depletion.

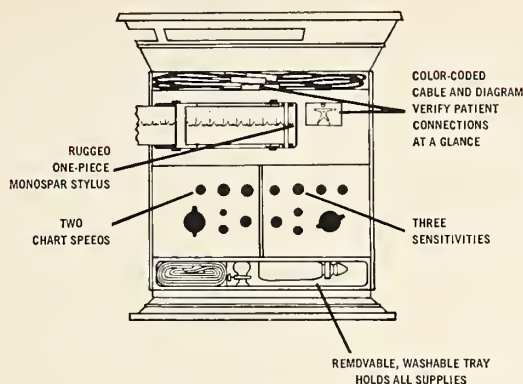
'Dyrenium' was tested in more than 5,000 patients. Documented case reports of 633 patients showed complete or adequate control of edema in 76 per cent (complete control in 34 per cent and adequate control in 42 per cent).

Case reports showed that of 183 patients who did not respond adequately to treatment with thiazides or other diuretics, 63 per cent were adequately or completely controlled by 'Dyrenium' alone.

Clinical studies also showed that patients who experienced only a partial response to treatment with thiazides alone often showed

(Continued on page 202)

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Rx REVIEWS (Continued)

remarkable improvement when 'Dyrenium' was used concomitantly. The drug also proved effective in combination with other diuretics, including the mercurials and spironolactone. The addition of 'Dyrenium' to thiazide therapy usually produces marked weight loss, increased sodium and chloride excretion and increased urine volume.

A unique feature of 'Dyrenium' is that it does not produce potassium depletion and resultant hypokalemia. Used in combination with thiazide diuretics, 'Dyrenium' reduces the potassium loss produced by those drugs.

Specific indications for 'Dyrenium' are treatment of edema associated with congestive heart failure, cirrhosis, the nephrotic syndrome and late pregnancy. It also has been effective in steroid-induced edema, idiopathic edema and edema due to secondary hyperaldosteronism.

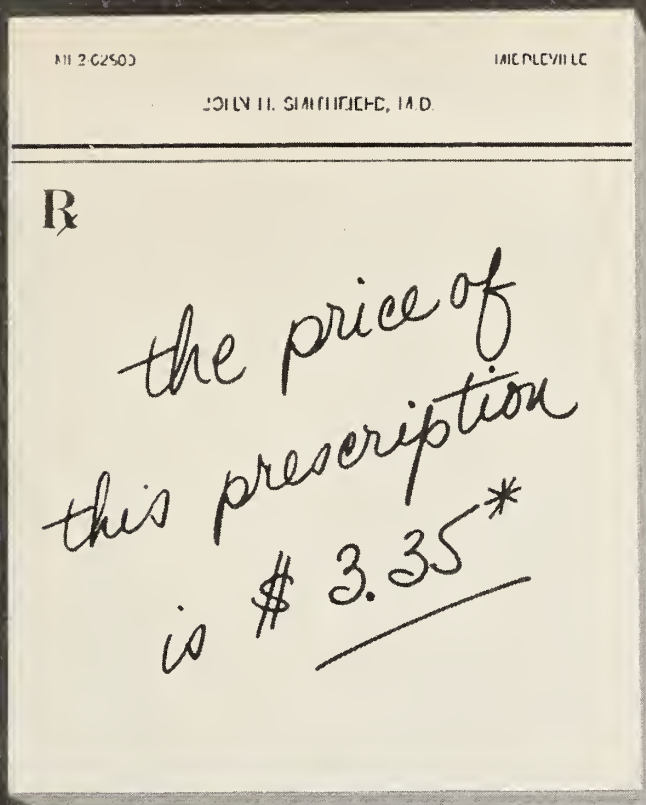
Contraindications are severe or progressive kidney disease or dysfunction, with the possible exception of nephrosis, and severe hepatic disease.

'Dyrenium' is believed to have two actions which distinguish it from other diuretics. These are a direct effect on the processes of sodium and other ion transfer in the distal rather than the proximal renal tubule and the ability to antagonize the effects of aldosterone.

As a result, 'Dyrenium' promotes excretion of sodium and chloride while conserving potassium, ammonium and titratable acid. When 'Dyrenium' is given to patients with secondary hyperaldosteronism, there is an increase in sodium and chloride excretion and a decrease in the excretion of potassium, hydrogen and ammonium.

Triamterene is a chemical in the pteridine group, a class of compounds originally discovered in the pigments that provide the beautiful coloring in butterfly wings and fish scales. Its diuretic activity was first discovered in tests with rats early in 1957 at Smith Kline & French.

Triamterene is available in 100 milligram capsule form in bottles of 100. The usual starting dosage is one capsule once or twice a day after meals. Maintenance dosage may be one capsule daily or one capsule every other day.



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Somewhat amazingly, \$3.18 is correct. Even if you eliminated pharmaceutical manufacturer's net profit, your patient would pay only about 17 cents less for the average prescription—hardly a deciding factor in having it filled. Of course, this assumes that pharmaceuticals could continue to be available without profit (where do new miracle drugs come from, if not profit?).

American pharmaceuticals today may well be America's biggest bargain.

Pharmaceutical Manufacturers Association/1155 Fifteenth Street, N.W., Washington, D. C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

*Average prescription price, 1963. National Prescription Audit, R.A. Gosselin, Dedham, Mass.



County News St. Clair County

The following resolution was adopted unanimously by the St. Clair County Medical Society in session January 7, 1965.

Whereas: The members of the St. Clair County Medical Society are interested in good medical care of all people;

Whereas: The members of the St. Clair County Medical Society feel that recipients of I.D.P.A. deserve the same quality of medicinal care including medications;

Whereas: The present Drug Manual as printed does not allow sufficient latitude to select medications as one would for other private patients;

Whereas: There is sufficient evidence that even the cost of medication can well be increased in certain instances; and

Whereas: The usage of the present Drug manual by participating physicians is cumbersome and time consuming procedure which detracts from the primary purpose of expeditious diagnosis and treatment of patients;

THEREFORE BE IT RESOLVED, that the House of Delegates of the Illinois State Medical Society withdraw their approval of the present Drug Manual.

Appointments

Dr. Louis R. Limarzi, 910 N. East, Oak Park, has been appointed Secretary-Treasurer of the University of Illinois Medical Alumni Association. He began the duties of this office September 24 at the association's Executive Council Meeting, held at the University's professional campus in Chicago.

Dr. Limarzi has been an active alumnus since his graduation in 1930. He will assist the president of the medical alumni (6,465 members) in arranging the association's annual activities. These activities include an alumni sponsored Freshman Orientation Luncheon



Dr. Hassan Najafi

held on campus in September, and the Annual Seminar and Banquet held at the Sherman Hotel, Chicago, in May.

Nathan W. Helman, executive vice president of Mount Sinai Hospital, California Avenue at 15th Street, has announced the appointment of Dr. Hassan Najafi as a full time member of the hospital's medical staff. Dr. Najafi has also been appointed Assistant Professor of Surgery at The Chicago Medical School and Attending Cardiovascular Surgeon at the Veterans Administration West Side Hospital.

In his new position Dr. Najafi will participate in the care of patients and the teaching program for medical students, interns and residents in the department. He will also conduct research in the field of cardiovascular and thoracic surgery.

Perry F. Prather, M.D., retiring Commissioner of the Maryland State Health Department, has been named Special Consultant to the Executive Director of the National Commission on Community Health Services. Prather's appointment was announced today by Dean W. Roberts, M.D., Executive Director of the Commission. Roberts said that Dr. Prather will work initially with the Community Action Studies Project of the Commission.

Commissioner of the Maryland State Health Department since 1961, Dr. Prather served successively as Special Consultant to the U.S. Public Health Service; Deputy State Health Officer for Washington County, Maryland; Deputy Director, Director, and Chairman of the Board of the Maryland State Health Department. He has been a lecturer in Public Health Administration for the Johns Hopkins School of Hygiene and consultant to the National Institute of Mental Health. Before entering the public health field, Prather was for twenty-two years a country practitioner in Washington County, Maryland.

Lee Holder has been named Director of the Community Action Studies Project of the National Commission on Community Health Services. The announcement was made by Dean W. Roberts, M.D., Executive Director of the Commission. Mr. Holder, Associate Director of the Studies Project since May 1963, assumed his new duties on December 1.

The Community Action Studies are aimed at discovering what makes communities take action to improve their health services and what are the barriers to action. In addition to coordinating the studies of community health services now under way in twenty-two communities in the United States, Mr. Holder will be responsible for: an analysis of previously-conducted community health studies, a study of community action process for health, and a series of analyses of individual, successful community health actions.

(Continued on page 210)

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 One Week, March 1
 BOARD REVIEW COURSE IN ORTHOPEDICS,
 One Week, April 5
 GALLBLADDER SURGERY, Three Days, March 8
 SURGERY OF HERNIA, Three Days, March 11
 PEDIATRIC SURGERY, One Week, March 22
 PROCTOSCOPY & SIGMOIDOSCOPY, One Week, March 29
 VARICOSE VEINS, One Week, March 15
 GYNECOLOGY, Office & Operative, Two Weeks, February 22
 VAGINAL SURGERY, One Week, February 15, April 5
 BOARD REVIEW COURSE IN GYN-OB, Two Weeks, March 15
 OBSTETRICS, General & Surgical, Two Weeks, April 26
 BOARD REVIEW COURSE IN MEDICINE, Part II,
 One Week, March 29
 BASIC ELECTROCARDIOGRAPHY, One Week, March 1
 PATHOLOGY BOARD REVIEW COURSES FOR SPECIALTIES,
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 ARTERIOGRAPHY, Four Days, March 30
 ANESTHESIA, Inhalation, Endotracheal, Regional,
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Obituaries

Franz J. Blanke*, Des Plaines, died December 27, aged 39. A graduate of Universitat Koln Medizinische Fakultat, Cologne, Germany in 1951, he was on the staff of Lutheran hospital.

Julius Brams*, Chicago, died December 19, aged 67. In 1922 he graduated from the University of Illinois College of Medicine where he later became a faculty member. He worked as a radiologist at St. Elizabeth's for 40 years, at St. Therese's for 20 years and at Loyola University's Stritch School of Medicine as assistant professor of radiology.

John L. Canavan*, Chicago, died December 26, aged 77. In 1909 he was a graduate of Northwestern University Medical School. He was a member of the Fifty Year Club of ISMS.

Edward E. Cannon*, Chicago, died December 18, aged 47. A graduate of Rush Medical College in 1949, he specialized in Colon and Rectal Surgery.

Leon D. Carson*, Chicago, died January 9, aged 68. A graduate of Northwestern University Medical School in 1909, Dr. Carson was a staff member of Englewood hospital after 28 years in the Navy, during which time he was awarded the Bronze Star.

Maurice D. FitzGerald, Hollywood, Florida, formerly of Chicago, died December 27, aged 51. A graduate of Loyola University School of Medicine in 1937, he served on the staffs of Mercy and Little Company of Mary hospitals and was a former associate in radiology at County hospital.

Myron I. Ingram*, Chicago, died September 25, aged 70. In 1917 he had been a graduate of Chicago College of Medicine and Surgery.

Robert E. Kraft*, Collinsville, died December 31, aged 55. A graduate of the University of Illinois College of Medicine in 1935, he specialized in obstetrics and gynecology. He was a former chief of staff at St. Mary's and a staff member of Christian Welfare hospital.

Louis L. McIntyre*, New Boston, died December 14, aged 85. A graduate of Northwestern University Medical School in 1907, he was retired at the time of death. He was a member of the Fifty Year Club of ISMS.

Albrecht H. Meyer, Chicago, died August 17, aged 68. In 1920 he graduated from Medizinische Akademie Dusseldorf, Germany, and specialized in psychiatry.

Herbert Natkin*, Chicago, died December 29, aged 46. A graduate of Chicago Medical School in 1945, he was a staff member of Northwest, Franklin Boulevard Community and Mount Sinai hospitals.

Emil A. Ochsner*, Rockford, died December 7, aged 86. In 1909 he graduated from the University of Illinois College of Medicine. He was an emeritus member of ISMS.

Frank E. Pierce*, Chicago, died December 10, aged 91. He was a surgeon on the staff of Mercy hospital until his retirement in 1944. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Walter J. Price, Tremont, died December 2, aged 93. In 1895 he graduated from Rush Medical College.

Anthony Sammis*, Bethalto, died December 19, aged 50. In 1942 he graduated from Chicago Medical School.

John Shutack*, Joliet, died August 4, aged 68. He graduated from Chicago College of Medicine and Surgery in 1917.

Edward C. Turner*, Savanna, died December 19, aged 62. In 1927 he graduated from the University of Illinois College of Medicine and served at Savanna City hospital where he became head of the medical staff. He was a member of various medical organizations.

George F. Van Gorder*, Danville, died December 21, aged 64. A graduate of the University of Michigan Medical School in 1928, he specialized in occupational medicine. Recently retired, he was former medical director for General Motors.

Halleck B. Warren*, Breese, died November 30, aged 76. He graduated from St. Louis University School of Medicine in 1915 and practiced in Breese for 48 years and became head of the medical staff of St. Joseph hospital.

David F. Whited*, Dahlgren, died December 6, aged 91. A graduate of the University of Nashville Medical Department in 1899, Dr. Whited had practiced for 65 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

**Indicates member of Illinois State Medical Society.*

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Meeting Memos



February 25-March 18—A continuing PG Course on Clinical Electrographic Interpretation will be held at the Cardiovascular Institute Hahnemann Medical College and Hospital, 230 North Broad Street, Philadelphia, Pa. The lectures for the next four weeks will be: Feb. 25—Coronary Artery Disease; Acute Transitory Coronary Insufficiency; Atypical Myocardial Infarction Patterns; and Anterior Wall Myocardial Infarction. March 4—Posterior Wall Myocardial Infarction; Subendocardial Infarction; LBBB and Myocardial Infarction; and RBBB and Myocardial Infarction. March 11—Myocardial Infarction Patterns Masking Other Electrocardiographic Abnormalities; Arrhythmias Associated With Acute Myocardial Infarction. March 18—Acute Cor Pulmonale; Chronic Cor Pulmonale; Pericarditis; and Myocarditis.

March 11-13—The American Medical Association and the American Bar Association have joined forces to sponsor the 1965 National Medicolegal Symposium at the Dunes Hotel in Las Vegas.

The meeting will provide the physician with an excellent educational opportunity on an important part of his professional life. Some 1,200 physicians and attorneys are expected to attend.

The biennial Medicolegal Symposium, sponsored solely by the AMA in the past, was considered to be the outstanding meeting of its kind. Participation by the ABA promises an even more informative program.

Joint AMA-ABA sponsorship of the 1965 National Medicolegal Symposium was agreed upon by the AMA-ABA Liaison Committee.

Thomas Boodell, chairman of the ABA Liaison Committee, stated, "The AMA is to be congratulated on its individual sponsorship of this very worthwhile meeting in the past, and the ABA appreciates the opportunity to co-sponsor such a program."

According to Robert B. Throckmorton, AMA general counsel, topics to be covered include

the common goals and ideals of law and medicine, the medical witness, current litigation, and tax problems. Trial vignettes will be used to dramatize courtroom situations.

The meeting will start at 2 p.m., Thursday, March 11, and conclude at noon, Saturday, March 13.

Registration fee for the symposium will be \$25.00, which will cover the cost of a luncheon on Friday, a reception and a copy of the proceedings.

Advance registration cards may be obtained by writing to Mr. Robert B. Throckmorton, general counsel, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

March 27—The Illinois State Surgical Division of the International College of Surgeons will hold its scientific meeting at the United States Naval Hospital, Great Lakes, Illinois. Commanding Officer Frank P. Kreuz, a Fellow of the College and the program chairman, invites all surgeons in the area to attend the meeting. Featured topics and speakers will be Partial Hepatectomy, W. J. Fouty, LCDR, MC, USN; Surgical Treatment of Renal Hypertension: Case Presentations, D. W. Hopping, LCDR, MC, USN; Internal Hemorrhoidectomy by Rubber Band Tourniquet Technique, F. E. Banich, LCDR, MC, USNR; and Treatment of Gas Gangrene by Hyperbaric Oxygen: Case Presentation, H. R. Cowell, LCDR, MC, USNR.

March 29-April 10, 1965—The Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Bronchoesophagology from March 29 through April 10, 1965. This course limited to fifteen physicians, will be under the direction of Paul H. Holinger, M.D., and will be held at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago.

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Adolescent Program,
Dr. Daniel Schiff, Director

This is one in a series of advertisements describing some of the services offered at the hospital.

Elections

Charles T. Higgins of Montgomery, Alabama, has been elected president of the National Association of Sheltered Workshops and Homebound Programs. Mr. Higgins, assistant director of the Alabama Society for Crippled Children and Adults, succeeds Dr. Howard G. Lytle of Indianapolis as NASWHP head.

New Films

Thirteen years of work and the special knowledge of an expert on mushrooms were needed to mass produce large quantities of penicillin, the first antibiotic.

A new educational slide film, released recently by Wyeth Laboratories, Philadelphia, begins with Sir Alexander Fleming's first observations of penicillin in England in 1929. Development of the drug through more than a decade of research still left the scientists faced with the problem of how to produce penicillin in large quantities.

In 1940, Raymond Rettew, a mushroom biologist in West Chester, Pa., studied methods for growing and extracting penicillin. Two years later, with the help of Wyeth Laboratories, he was able to direct the mass production of penicillin to meet the needs of the Armed Forces during World War II.

Serving as a primer in penicillin, the slide film, "The First Antibiotic," describes the manufacturing process and outlines the chemical

formulae that make possible a wide variety of semisynthetic penicillins.

Available on loan from Wyeth Laboratories, the set includes 36 slides and a magnetic tape recording to describe them. A script to be read with slides is also available and can be used instead of the tape recording.

Requests for copies of "The First Antibiotic" for showings to medical or educational groups should be sent to Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

New Literature

The National Dairy Council's familiar Guide To Good Eating, which has been in existence and continuous use since 1942, has recently been revised to reflect the 1963 Recommended Dietary Allowances.

Only those dairy foods important for their calcium contribution are included in the Milk Group. The amounts of milk recommended for the different age groups have been changed slightly. Corresponding copy changes have been made on the back of the leaflet in the Milk Group.

The Meat Group, Vegetables and Fruits and Breads and Cereals remain unchanged. In the Additional Foods section on the back of the leaflet the need to give special attention to food sources for iron for children, teen-agers, pregnant and lactating women is pointed out.

The revised "Guide" leaflet, size 7¼ x 11 inches, is now available by contacting: Alice M. Couley, National Dairy Council, 111 North Canal Street, Chicago, Illinois 60606.



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president . . .



Edward A. Piszczek, M.D.

As we gird ourselves for the last, all-out battle to determine whether or not this nation shall maintain an independent system of health care, we must review several facts to better clarify our position and direct our actions in the hectic months to come. They follow in this order:

1. There is more at stake in this struggle than merely the determination of which financial system shall subsidize medical care for the aged. The issues reach far beyond, to the fundamental principles of our way of life. The choices laid before our citizens are whether we shall retain a system of medical care consistent with American tradition, or whether we shall plunge that system into the abyss of welfare conrol.

2. There is no turning back. We as physicians can claim no "second chance." If we fail now, federalized health care will prevail permanently to undermine and ultimately destroy the finest system of medical care the world has ever known.
3. We did not ask for this fight. In all good conscience and in the best interests of our patients and our profession, however, we are morally obligated to fight to the finish with every resource at our command.

The struggle will not be easy. The proponents of Medicare are well-organized and have constructed a formidable, effective propaganda machine. Despite these tremendous odds we may count ourselves as fortunate, however, for we possess the ultimate weapon—TRUTH. With clear conscience and in clear terms we are able to prove that federalized medical care is not only expensive, but inadequate and inefficient as well. In addition, we can offer an alternate plan named ELDERCARE which provides better care than Medicare at lower cost, and which is consistent with our cherished American principle of free enterprise.

We have spared no expense or effort to relate these facts to the public; the contents of these pages attest eloquently to that fact. In addition, the last several pages contain articles which will help to make YOU a more objective, oriented source on this crucial issue.

While this guidebook catalogs our collective attempts to achieve public support, it cannot hope completely to inspire your *personal* support. That task, ultimately, must be borne by each of you alone. As the last, direct link of communications with the public, you must become personal testimonials for the principles of free medicine in which you believe and under which you are privileged to practice. You must defend and support your position in speeches, with literature ordered for your office, and through personal contacts with friends, associates and patients. In short, you must become one-physician arsenals in the cause of free medicine.

With each physician doing his part, the truth will build in momentum until—like a cascading waterfall—it will drown out the voice of the opposition.

Once again, we did not ask for this fight; but it is not in our make-up as physicians to turn away from struggle and adversity. As we remain with a patient until his health is restored, let us stand by our principles until the threats against our cherished system of medical care are vanquished.



Abstracts of Special House of Delegates Session February 7, 1965

By official action, the Board of Trustees (upon recommendation of the Finance Committee) instructed the Secretary of the Illinois State Medical Society to issue the official call for a special meeting of the House of Delegates. The notice was mailed January 20, and the meeting scheduled for Sunday, February 7, 1965 at the Congress Hotel, Chicago.

The specific purposes for calling the meeting were outlined in the notice:

- (1) "to explain the Illinois State Medical Society's educational campaign, in co-operation with the American Medical Association, relating to national health legislation, including but not limited to policy concerning health care for the needy, and
- (2) "to counsel with the official representatives of county medical societies regarding the various mechanisms by which this educational campaign may be financed."

Reference committees were appointed as follows:

Committee on Credentials

Francis W. Young,
Morgan M. Meyer,
Co-Chairmen
Charles J. Weigel
Jack Williams
C. Elliott Bell

Rules and Order of Business

Joseph R. Mallory, Chairman
Norman Powers
William K. Ford
George F. Lull
Karl L. Vehe

Tellers and Sergeants at Arms

L. S. Tichy, Chairman
Raymond H. Conley
George Kaiser
William H. Walton
Donald Nellins
Lawrence J. Rossi

Committee on Miscellaneous
Business

Harold A. Sofield, Chairman
Fred A. Tworoger
Harold C. Lueth
Chauncey C. Maher, Jr.
Paul W. Sunderland
George B. Callahan

In order to clarify for the delegates present, the problems before them, a panel presentation was given with Dr. Wm. A. Adams as moderator.

Dr. V. P. Siegel, chairman of the ISMS Committee on Legislation spoke on "Legislative Aspects and the Basic Program";

Mr. Robert L. Richards, Executive Administrator presented an outline of services available at headquarters, on "Special Communications and Professional Speakers Bureau";

Dr. Leo P. A. Sweeney, chairman of ISMS Committee on Public Relations outlined "The Use of Newspapers, Radio and Television in the Program";

Dr. Carl E. Clark, chairman of ISMS Finance Committee of the Board of Trustees, presented the "Financial Report and the Suggested Mechanisms for Program Financing".

The House, during the session, heard remarks by Dr. Donovan Ward, President of the American Medical Association; by Dr. Percy E. Hopkins, chairman of the AMA Board of Trustees, and by James Foristel, LL.B., Legislative Representative in the Washington Office of the AMA. Dr. Piszczek, president of ISMS, read portions of the presidential address given by Doctor Ward to the AMA House on Saturday, February 6.

At the request of the Speaker of the ISMS House, Dr. E. W. Cannady, resolutions were presented. Three were received and reviewed by the Reference Committee before final recommendations were made.

Dr. Harold A. Sofield, chairman of the Reference Committee on Miscellaneous Business, assumed the chair and opened the hearing for detailed and free discussion from the floor.

He stressed as his first statement to those present, that only those items contained in the official notice of the meeting could be discussed by the Reference Committee.

The Resolutions were considered. The Resolution #1, presented by Crawford County, was ruled outside the province of the meeting by a standing vote. It was suggested that if the county society so desired, this resolution could be presented at the May meeting of the House.

Resolutions #2 and #3 were discussed simultaneously. Resolution #2 called for a dues increase of \$100; Resolution #3, for an increase of \$50. It was suggested from the floor that a per capita dues increase for all full dues paying members in the amount of \$25 would provide the funds necessary to conduct the informational campaign until the House of Delegates would meet again in May. Additional consideration can be given at that time to any existing need or emergency situation.

By a standing vote, the amount of \$25 was supported overwhelmingly as a supplemental dues increase for 1965. The Reference Committee assured all in attendance that the vote would receive every consideration by the Committee in preparation of its report to the House.

After the luncheon, the report of the Reference Committee was presented by the chairman, Dr. Sofield.

Upon request from the floor, Dr. Jacob E. Reisch, secretary-treasurer, outlined the proposed expenditures and presented the "Eldercare Informational Campaign" in outline.

The vote was called for, and no dissenting vote was registered. Therefore the speaker asked that the record show that the report of the Reference Committee had been accepted unanimously.

Dr. E. W. Cannady, speaker, expressed his appreciation to the members of the Reference Committees which had served the House; he extended special thanks to the delegates, officers of the state society and county and branch societies who attended the called meeting.

He asked that each physician present carry back to the membership of his county society the important material presented, and become an important part of the statewide "Eldercare Informational Campaign".

The meeting adjourned at 3:00 p.m.

REFERENCE COMMITTEE RECOMMENDATION

Your Reference Committee, convening at the direction of the Speaker of the House of Delegates and pursuant to the notice which called a special meeting of this House of Delegates, received resolutions pertaining to the two items contained in the official call:

- (1) to explain the Illinois State Medical Society's educational campaign in co-operation with the American Medical Association, relating to national health legislation, including but not limited to policy concerning health care for the needy; and
- (2) to counsel with the official representatives of county medical societies regarding the various mechanisms by which this educational campaign may be financed.

Your Reference Committee takes this opportunity to express its thanks to those physicians who availed themselves of the privilege of expressing their views. Your Reference Committee has weighed all of the commentary and reports very carefully and offers to this House of Delegates this following substitute resolution for endorsement:

WHEREAS the American Medical Association has developed a program designed to provide extensive health care benefits for the elderly within the framework of the freedom of American medicine; and

WHEREAS the Doctors' Eldercare program fulfills the health care needs of the financially limited elderly, insures free choice of physician, and provides high standards of medical care; and

WHEREAS an informational program is essential to promote understanding of the proposals and to generate acceptance of the Doctors' Eldercare program, now therefore be it

RESOLVED, That the Illinois State Medical Society House of Delegates endorses and supports the American Medical Association's Eldercare program, and be it further

RESOLVED, That in order to provide the funds which will be required to conduct such an informational campaign, and to support the overall activities of the Illinois State Medical Society, this House of Delegates does hereby enact, for the year 1965, a supplemental per capita dues assessment against each component society in the amount of \$25.00 *to apply to full dues paying members.*

A public information campaign . . .



If we are going to win public support, the citizens of our state and nation must be told the **FACTS** about Eldercare and Medicare. They not only must learn that Medicare is expensive, inadequate and a threat to our precious free enterprise system of medical care, but that **ELDERCARE** gives better care at less cost for those who really need it.

To effectively convey this message to the citizens of our state, Operation **ELDERCARE** was launched in February, 1965 and will continue through May with a broadside of public information emanating from every conceivable communications media. There will be statewide radio and television announcements; newspaper ads; outdoor billboards; and instructive brochures available for direct mailings and pamphlet racks.

This communication program is unequalled in ISMS campaign history. Along with the personal, active support of every physician in the state, it provides the effective weapons necessary for defeating Medicare.

Here's how Illinois citizens
will see and hear the **FACTS**
about Medical Care for the Aged . . .

To make you a more informed source . . .

The Illinois State Medical Society is pleased to reprint the following two articles. To both *Reader's Digest* and *U. S. News and World Report*, for their courtesy in extending us special reprint privileges, the Society extends its thanks and gratitude.

Reprinted from the February issue of The Reader's Digest. ©1965 The Reader's Digest Association, Inc.

Medicare—Or Medical Care?

BY WALTER H. JUDD, M.D. *Former U.S. Representative from Minnesota*

We must not play politics with the health of the nation. In this trenchant analysis, a critic distinguished both as a doctor and as a legislator strips away the propaganda from the administration's medical program



Shortly before the election last November, President Johnson was asked, "Mr. President, is Medicare going to be on your list of 'must legislation' for next year?" The President answered firmly, "Top of the list!"

Thus, advocates of federally financed health plans, who have fought a losing fight for nearly 20, gained new hope and confidence. Indeed, since the election, these advocates have talked of a "mandate" for their present favorite legislative formula: medical care for the aged under Social Security.

Congress, therefore, is faced with this solemn question: What shall the law they pass provide for sick and needy people over 65—*medical* care or merely Medicare?

Seldom has an important piece of legislation been so confused and camouflaged by propaganda and promises. The name Medicare itself is a notable case of mislabeling. Those who have studied the King-Anderson Bill and the various proposals that have succeeded it know that Medicare does not provide *medical care* for the aged; it provides only limited

hospital and nursing-home care plus a few fringe benefits. Despite the slogans and the oratory, Medicare would provide:

- Nothing for doctors' bills, whether office visits or house calls.
- Nothing for surgeons' fees, nothing for dentists' bills.
- Nothing for drugs, medicines, dentures, eyeglasses, hearing aids.

Then what *does* Medicare provide? Under the administration bill which passed the Senate last fall (the Gore Amendment to the Social Security Act), these benefits—and only these are available:

- Up to 45 days in the hospital with no deductions; up to 90 days, if you pay \$10 per day for the first nine days; up to 180 days after a deduction of 2½ times the average cost of one day's stay in the hospital.

Hospital care would consist of bed-and-board, plus nursing and related services "customarily furnished by the hospital to inpatients." Specifically *excluded*, however, are "medical or surgical services provided by a physician, resident or intern, except in the fields of pathology, radiology, psychiatry or anesthesiology."

- Nursing-home care would consist of a maximum of 60 days in a "skilled nursing facility" *after* discharge from the hospital, and would include medical services provided under an approved teaching program by interns and residents of the hospital with which the nursing facility is affiliated. (Few such hospital-affiliated nursing homes exist today!)

- Outpatient hospital services would be furnished for diagnostic studies only, during any 30-day period after an initial

payment of \$20. Home health service would be furnished by a visiting nurse for a maximum of 240 visits in the calendar year.

Medicare advocates claim: "This system permits people to contribute during their working years to the heavy costs of medical care in their later years."

Says Dr. Ernest B. Howard of the American Medical Association: "Rarely have so many lies been packed into so few words."

NOT ON THE LABEL. Indeed, Medicare, in many respects, is the opposite of what some proponents claim it to be.

Medicare does not *permit*; it compels every wage earner to participate in the plan.

The wage earner does not *contribute*; he is *taxed*.

The Medicare taxes paid "during the wage-earners' working years" *do not* go to pay "the heavy costs of medical care" in *their* later years. The taxes they pay *today* would go to pay today's beneficiaries. Tomorrow's benefits would have to be paid for by tomorrow's taxpayers.

Under Medicare the secretary earning \$5600 would pay exactly the same tax as the executive earning \$56,000, since the tax base would be on earnings up to \$5600. The tax burden, therefore, would be borne largely by those earning \$5600 and less—the same people who even today are casting worried eyes on their paychecks, aware of the heavy burden imposed by Social Security deductions plus income tax.

And here is the final irony: Because Medicare provides the same aid to all over 65—*whether they need it or not*—its benefits to those who do need aid are wholly inadequate.

MANDATE FOR MEDICARE? Current propaganda for the administration bill interprets the Democratic victory of 1964 as a "public mandate for Medicare." Yet, since 1961, when Medicare started out in high esteem, the weight of public opinion has shifted (as increasing numbers of people learned the facts. The day after the 1964 elections, Samuel Lubell, of United Press International, reported on his nationwide tour ringing doorbells and questioning voters about election issues. He learned from his interviews that, although there was a feeling that "older people need help, details of the administration's proposal are not understood and the opposition of voters rises when they learn how limited is the assistance that would be provided and what it would cost in tax increases."

Many Americans are gravely concerned about the future of Social Security and opposed to heaping any additional burdens upon it. Their concern is justified. The payroll tax and the tax base both have been climbing steadily, from the original two percent of the first \$3000 of income in 1937-49, to 7.25 percent of \$4800 in 1964-65, and will increase to 8.25 percent in 1966, even *without* Medicare. If the Medicare bill is passed, it will necessitate an increase to nine percent of \$5600 in 1966-67 and at least ten percent the following year.

Nor is an end in sight. Dr. Barkev S. Sanders, who for 35 years was medical and welfare statistician for the government, reminds us that the government always underestimates future welfare costs. "On the basis of available evidence," Dr. Sanders reported in *Nation's Business*, "even in the first year of Medicare, its cost would be at least three

times the estimated cost. It is more probable that the multiplier would be four."

Inevitably, "medical care under Social Security" would become a political football. The first step would be to admit openly that Medicare is inadequate; next, a little more would be added—always in an election year. And, as benefits increased, the tax inevitably would rise. In 1961 a Medicare pioneer, former Rep. Aime J. Forand (Democrat) of Rhode Island, virtually admitted that this would be the scheme. "If we can only get our foot inside the door," he stated, "we can expand the program after that."

WHAT'S WRONG? The fault of the government medical planners is basically the assumption that most Americans over 65 are sick, destitute and incapable of taking care of themselves. Pro-Medicare people have presented a frightening image with such statements as "Incomes of the aged are inadequate even for a modest level of living. . . . The income of the great majority of the aged is little more than a monthly Social Security check. . . . More than half the aged have incomes of less than \$1000 a year."

Yet the 1963 Report of the President's Council on Aging itself provides facts to contradict such statements:

The "less than \$1000 a year" figure is based on the statistical trick of averaging in the *zero* incomes of wives and unemployable dependents who are over 65, while completely ignoring the fact that the actual income of the head of the house, or the family income, may be significantly greater.

Only one third of the total income of Americans over 65 (*35 billion dollars*)

comes from Social Security and other government retirement programs.

The income of the aged has risen faster than the cost of medical care, and faster than the income of the population as a whole. "While the number of older people increased by about 40 percent in the past decade," the Council on Aging states, "their total income rose by more than 130 percent. This compares, for the same period, with an increase of 80 percent in the total personal income of the entire population."

Surveys in 14 states show that between 70 and 91 percent of patients over 65 pay their hospital bills promptly, largely out of income, savings and private insurance. (This is a much higher percentage than that of younger people.) Ten hospitals in Allegheny County, Pennsylvania, have reported that of 19,996 patients over 65 admitted during 1962-63, 97.4 percent paid up promptly, 76.9 percent with private insurance of their own funds, and 20.5 percent with benefits from the Kerr-Mills program. Only 2.6 percent of the hospital bills were unpaid when the survey was made.

How do we reconcile these facts with the contention that the older American's problems come "dangerously close to making him a second-class citizen"?

WIDESPREAD ILL-HEALTH. Equally false is the assumption that older Americans are mostly feeble and constantly ill. The Senate's Special Committee on Aging, for example, was told that four out of five old people suffer from "chronic" illnesses, and that they visit doctors 36 percent oftener than the total population. To most laymen "chronic illness" means an ailment that is severe and disabling. But

to doctors the word "chronic" denotes duration and not severity of an illness. Statistics of the U.S. National Health Service show that more than half of older Americans who have chronic health problems are able to carry on their normal activities.

That the aged visit doctors 36 percent oftener than the total population sounds horrendous; but that percentage means exactly 1.8 more visits per year. Those over 65 average 6.8 visits to the doctor's office each year, compared with an average of *five* visits for the total population. And Medicare, of course, would not pay for any visits!

A Health Information Foundation survey of elderly Americans not in institutions shows that most of them enjoy reasonably good health. Only 14 percent of those surveyed were classified as "very sick." Of the remainder about half considered themselves healthy; the other half reported some disability but not enough to interfere with physical functioning.

WHAT IS THE ANSWER? Fortunately Medicare is not "the only answer" to the health problems of the aged. Better answers are available. What we need is a voluntary system that will provide good medical care for *all* Americans, including those over 65 who are in need. Can this be provided?

Medical and hospital care already is within reach of a majority of Americans through voluntary health-insurance plans. Of the 18 million persons over 65, more than ten million are now covered by one or another such plan.

For those who have no insurance and cannot qualify under the age limits of

standard insurance policies, there is the popular "Connecticut 65" plan, inaugurated in 1961. Thirty-two Connecticut insurance companies are pooling their risks in a voluntary association which offers noncancelable insurance covering hospital, medical and surgical expenses to Connecticut residents over the age of 65. Similar plans have been started in New York, Massachusetts, North Carolina, Virginia, Texas, Ohio and California. The California plan is about to become "Western 65," and will operate in Arizona, Nevada, New Mexico, Oregon and Washington, as well as in California.

To make sure that older policyholders will be able to buy their own insurance, Rep. Frank T. Bow, of Ohio, has introduced a bill which deserves special consideration. The bill would provide an income-tax credit equal to the amount of the premium up to \$150 for those with incomes under \$4000, or up to \$300 for a couple whose combined income is less than \$8000. It would authorize the same tax credit to a relative who wishes to purchase health insurance for a family member over 65. The credit would also be available to any employer who provides medical-care insurance for his retired employees.

MAA-KERR-MILLS. At the heart of this voluntary system is Medical Aid for the Aged—generally called Kerr-Mills—which, properly implemented, would guarantee that no one over 65 shall be without medical care because of inability to pay.

Unlike Medicare, Kerr-Mills can provide, *in addition to hospital and nursing-home care*, funds for doctors' bills, dental care, private nursing when needed, laboratory and X-ray facilities, and prescribed

drugs. This plan, available to the needy and near-needy without cost, is financed by federal funds matched by funds of the participating states. Since the law was enacted in 1960, 42 states have authorized participation. Benefits vary from state to state, and in some states the plan is not working as well as it might; but these faults are local, and experience shows that they are correctable.

Medicare advocates have two major objections to Kerr-Mills. First, the plan is operated by the states, and hence is beyond the control of the federal government. Second, the plan is exclusively for those over 65 whose low or marginal income will not enable them to bear the cost of the medical care they need. There are no benefits for those who can afford good medical care.

The "social planners" complain that needy old folks must pass a "means test" (which they wrongly equate to a "paupers oath") in order to qualify for Kerr-Mills benefits. Actually, this test is applied by most churches, private charities, labor unions—and by government agencies like the Veterans Administration, Low-Rent Public Housing and other programs. The Department of Health, Education and Welfare now uses the same means test to determine whether the earnings of a person over 65 are high enough to disqualify him from receiving his normal Social Security benefits.

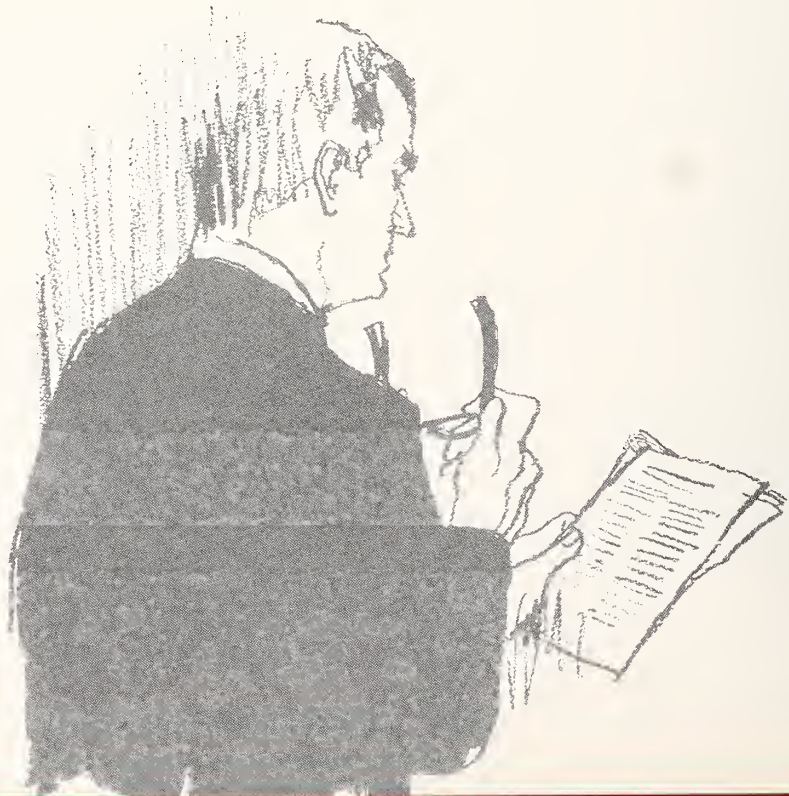
Probably some form of liberalizing the methods of determining need should be included among the other amendments designed to make the Kerr-Mills Plan everything it should be; but Congress should retain in the law a proper safe-

guard against the waste of public funds and the inroads of the "free riders."

CAVEAT EMPTOR. Thus there are sound alternatives to the obviously unsound plan called Medicare. There is no reason, therefore, why Congress should be stampeded into accepting a plan that has only political expedience in its favor. A majority of the people are now aware of the administration bill's shortcomings. And if such a bill were to be enacted into law, bitter disillusionment would begin as soon as the first benefits were applied for.

It must be recognized that no government programs by themselves can provide a fully adequate solution to the admitted need of many older people for assistance with their health problems.

But there are some things that government can and should do to help. The administration has the opportunity to make an effective contribution toward adequate medical care for all, and at lower cost to the taxpayers in the lower bracket, (1) by endorsing and promoting voluntary hospital and surgical insurance; (2) by supporting supplementary plans such as "Connecticut 65" and something like the Bow Bill; (3) by including and honestly supporting the Kerr-Mills program, which will take care of those over 65 who are in need of medical care and cannot pay for it themselves. By adopting such a course President Johnson can be instrumental in bringing to *all* Americans of *all* ages medical care that is truly worthy of a great society.



"Reprinted from 'U.S. News & World Report,' published at Washington."

State Medicine for U.S.— How close is it?

Look at the health care that American people get at Government expense, and this becomes clear: The United States already has gone far along the road toward state medicine. Now President Johnson is asking for more speed in that direction.

A big stride down the road toward state medicine is being proposed by President Johnson as his No. 1 objective for 1965. All signs are that Congress is in a mood to approve.

Already millions of Americans—more than 30 million of them—can either get free medical and hospital care or get some kind of Government help in paying doctor and hospital bills.

The cost of existing forms of state medicine in the year just past was 9 billion dollars.

Mr. Johnson now wants to add to present aid a new program of hospital care for persons 65 years of age or older, to be financed by a tax on payrolls, under the Social Security system.

Cost of this new program in its first full year: about 2 billion dollars.

Estimates are that those added costs, once accepted, will rise rapidly in succeeding years.

It is just one step from providing free hospital care for all persons over 65 to paying doctors' bills for them as well.

Then there are only a few more steps to a state system providing complete hospital and medical care for everybody.

THE STORY IN EUROPE. In almost all the nations of Western Europe, all of these steps have been taken. Hospital bills, costs of convalescent homes and rehabilitation, doctors' bills, even drugs, eyeglasses and false teeth are covered by many of Europe's programs of state medicine—all deeply entrenched.

Now Canada, next door to the U. S., is moving strongly in the direction of a full system of state medicine.

The push of the United States toward a national health service under Government control has been a creeping one, to date. What President Johnson is proposing is that this push be speeded.

Charts recently compiled show how

far the process already has gone.

As you can see by the facts, more than one fourth of all dollars spent on health care in 1964 were public dollars. The total health bill, public and private, came to 35.4 billion dollars. The private part of that bill was 26.4 billion. The public share was 9 billion—an increase of 2.6 billion over the public spending four years earlier.

There are many programs of state medicine now in operation.

Fastest growing program has been that known as Kerr-Mills, which provides federal aid for State programs of free medical care for indigent aged. Costs of the Kerr-Mills and other similar programs for the needy were 1.1 billion dollars in 1964. Back in 1950, such costs totaled only 51 million dollars.

The President now is proposing federal funds to help pay costs of medical and dental care for needy children, as well as for needy old folks.

A BILLION FOR VETERANS. American war veterans long have enjoyed a big and varied program of state medicine. More than 22 million veterans now are potentially eligible for hospital care and medical services. The Veterans Administration operates more than 160 hospitals. Cost of this big program for veterans last year amounted to more than 1 billion dollars.

Then, of course, the 3.1 million active or retired members of the armed forces and their 4 million dependents have their own program, under the military, that covers the whole wide range of medical and hospital care, as well as dental and psychiatric services. This cost is just under 1 billion dollars.

Cities and States long have had hospi-

tals of their own, available to the needy. Then there are State hospitals for the mentally ill.

Of the 1.7 million hospital beds in the U. S. in 1963, about 1.1 million, or 66.2 per cent, were in publicly owned institutions. State-owned hospitals accounted for 43.4 per cent of the total beds, community-owned hospitals 12.4 per cent, and federally owned hospitals 10.4 per cent.

Now more and more States are providing special hospitals and training centers for handicapped and retarded children. Mr. Johnson is proposing that the Federal Government provide financial aid to those programs.

New York City is an example of the extent and growth of state medicine in American cities. A recent study showed that in New York City alone public expenditures for medical care rose from 530 million dollars in 1961 to 734 million dollars budgeted for 1965, with the federal and State governments putting up about 40 per cent of the total.

PART THE PUBLIC PAYS. The magazine "Scientific American," reporting this study in its January, 1965, issue, said: "These outlays from tax funds account for nearly a third of the total bill for personal medical services rendered to the 2.8 million families in New York City, and for more than half of the cost of care received by New Yorkers as inpatients in hospitals and related institutions.

"Only a fraction of these public expenditures goes for the care of the destitute portion of the population that is 'on welfare.' Almost 80 per cent of the patients in New York municipal hospi-

tals are people who manage to cover their ordinary expenses but who lack the margin in income, savings or health insurance to pay the hospital and the doctor when they get sick."

In the nation as a whole, general hospital and medical care in State and city centers cost 2.4 billion dollars last year—and costs rise steadily.

FOR THOSE ON RELIEF. Nearly anybody on relief can get medical care at State and local expense, with the Federal Government often footing part of the cost. This applies to about 7.7 million people, including dependent children and those who are receiving old-age assistance.

The Federal Government contributes to the cost of health insurance programs for most federal workers and their families—6.3 million people. An estimated 2 million employees of State and local governments get similar contributions from their employers.

Nearly 50 million workers are eligible for hospital and medical benefits under workmen's compensation programs which, though privately financed, are often required by State governments.

Medical research is a huge and growing activity heavily financed by the Federal Government. Federal spending for such research last year exceeded 1.1 billion dollars. Most of this money is spent by the National Institutes of Health, which now has 68 clinical research centers in operation and authorization for a dozen more. Thousands of patients get treatment from the NIH while serving as research subjects.

The U. S. Public Health Service has

been providing a form of state medicine ever since its establishment in 1798, when it began giving medical care to sick or injured seamen. Now PHS operates scores of hospitals and clinics in addition to all of its far-flung activities in preventing disease.

All told, the Federal Government's share of the total public cost for health care was 4.6 billion dollars last year—more than three times the amount it spent 15 years ago.

State and local costs for health care in 1964 totaled 4.4 billions.

This was the first year since World II in which federal spending on health care exceeded that of State and local governments.

What you find, when you examine the situation, is that state medicine in the U. S. is on a huge and growing scale—even before Congress acts on the proposed new programs.

WASHINGTON'S CHIEF ROLE. Most of the state medicine at present, however, is provided for special groups—the indigent, war veterans or those in the military services. Administration, except for the military and veterans' programs, has been mostly by States or cities, with Washington's role chiefly that of helping to pay the costs.

Now the proposal is that the Federal Government begin to move in directly to set up a system of health care for the aged under Social Security.

Experience shows that programs in the field of social security, after being started on a limited basis, tend to be broadened rapidly. This is true of most federal programs.

TREATMENT, RESEARCH. The new Johnson program goes beyond hospital care for aged persons under Social Security.

Another important part of the program calls for establishing a network of 32 regional medical centers at a cost of 1.2 billion dollars in five years.

Those centers would provide treatment of patients as well as research and teaching in latest medical techniques.

Once those regional centers are established and operating, then community centers are expected to grow up.

Mr. Johnson has proposed federal loans to stimulate creation of "group practice" clinics to provide a wider range of medical service in communities.

The growing program of state medicine is expected to call for broad expansion of hospital facilities and for a large increase in the numbers of doctors and nurses. Mr. Johnson told Congress:

"At present the United States has 290,000 physicians. In a decade, we shall need 346,000."

To help supply this need, the President recommended federal grants to medical and nursing schools, and scholarships for medical and dental students who lack money for their schooling.

SPUR TO DEMAND. Rapid rises in the costs of medical and hospital care have helped to spur the growing demand for more Government help in meeting these costs.

In a recently published book, "The Economics of American Medicine," economist Seymour E. Harris reported: From the late 1940s to the latter part of 1961, the price of medical services increased more than 60 per cent and hospital costs increased at two and one third times the rate of all medical care—while all consumer prices rose only 28 per cent.

The American Medical Association recently reported that the cost of medical care per U. S. household went up 112.7 per cent between 1948 and 1962, while disposable income, after taxes, rose 50.6 per cent per household.

"THE BEST FOR ALL." Mr. Johnson's goal, he told Congress, is "to assure the availability of and accessibility to the best health care for all Americans, regardless of age or geography or economic status."

Here the President has pointed the direction in which this country is heading—toward more and more Government help in meeting health costs.

Once the needs of the aged and the children have been met, the next indicated step will be a Government attack on the medical needs of Americans of all ages.

This nation, already far along the road toward state medicine, now appears about to take another big stride in that direction.



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TEAMED FOR MORE EFFECTIVE PERFORMANCE. Therapeutic teamwork is of recognized importance in managing G.I. disorders because of interrelated physical and psychic factors. In ENARAX, therefore, the anticholinergic benefits of oxyphencyclimine HCl are augmented by the tranquilizer Atarax® (hydroxyzine HCl) for concerted action against pain, spasm and anxiety.

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TWO POTENCIES FOR MORE VERSATILE PERFORMANCE. ENARAX 5 is recommended when G.I. symptoms are present without x-ray evidence of peptic ulcer, functional bowel syndrome, and for many other G.I. dysfunctions. Each tablet contains oxyphencyclimine HCl 5 mg.; hydroxyzine HCl 25 mg. Prescribe ENARAX 10 when extra potency is desired—as in radiologically confirmed cases of ulcer or in hospitalized patients. Each tablet contains oxyphencyclimine HCl 10 mg.; hydroxyzine HCl 25 mg. Rx only.

...and when your Antivert®
patients are near or past
retirement age

Neobon®
geriatric supplement

helps keep them
'on the go'



Neobon combines hormones, essential hematopoietic factors, a digestive enzyme, and vitamins and minerals with the important amino acids L-lysine and glutamic acid. When used as adjunctive therapy, such medication has been shown to be of value in treating patients with the geriatric syndrome.^{1,2} You too can help your geriatric patients—with or without vertigo—lead a more active life by prescribing Neobon.

Each capsule contains:

(1) Vitamins and Minerals

Vitamin A
(acetate) 2000 U.S.P. units
Vitamin D (irradiated
ergosterol) 200 U.S.P. units
Vitamin B₁ (thiamine
mononitrate, U.S.P.) 0.5 mg.
Vitamin B₂
(riboflavin, U.S.P.) 0.5 mg.
Vitamin B₆
(pyridoxine HCl, U.S.P.) 0.5 mg.
Niacinamide, U.S.P. 50 mg.
Calcium pantothenate,
U.S.P. 5 mg.
Vitamin E (from alpha
tocopherol acetate) 5 I.U.
Rutin, N. F. 5 mg.
Cobalt (from cobalt
sulfate) 0.033 mg.
Molybdenum (from
sodium molybdate) 0.066 mg.
Copper (from copper
sulfate) 0.33 mg.
Manganese (from
manganese sulfate) 0.33 mg.

Magnesium (magnesium
sulfate) 2 mg.
Iodine (from potassium
iodide) 0.05 mg.
Potassium (from
potassium sulfate) 1.66 mg.
Zinc (from zinc
sulfate) 0.4 mg.

(2) Hematopoietic Factors

Iron (from ferrous
sulfate) 3.40 mg.
Vitamin B₁₂ (cobalamin
concentrate, N.F. as
Stablets®) 1 mcg.
Vitamin C (ascorbic
acid, U.S.P.) 50 mg.

(3) Digestive Enzyme

Pancreatic substance* 50 mg.

(4) Gonadal Hormones

Methyltestosterone 1.0 mg.
Ethinyl estradiol 0.006 mg.

(5) Amino Acids

L-Lysine 50 mg.
Glutamic acid 30 mg.

*Enzymatically active defatted material obtained from 250 mg. of whole fresh pancreas.

Precaution: Contraindicated in patients wherein estrogen or androgen therapy should not be used, as in carcinoma of the breast or prostate.

Dosage: One capsule, t.i.d. with meals, or as directed by physician.

Supplied: Bottles of 60 capsules. Rx only.

References: 1. Dufficy, R. G., Jr.: J. Am. Geriatrics Soc. 5:936 (Nov.) 1957.
2. Ende, M.: Southwestern Med. 38:625 (Oct.) 1957.

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AS I SEE IT FROM '360'

By ROBERT L. RICHARDS
Executive Administrator

SPECIAL ELDERCARE SECTION: A COMMENDATION

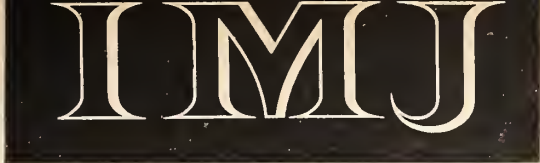
BELIEF IN THE CAPABILITY of a society dedicated to the ideal of freedom sometimes provides interesting comparisons on how to "get the job done." For six years the medical profession has found the task of telling the people of this country that the so-called Medicare bill is basically a hoax on those whom it supposedly would serve and particularly those who would have to pay for it.

Inadequately financed programs and modest efforts on the part of organized medicine to tell the story were thought to be enough to have the public understand. In addition there were some who felt that the cause had been lost so why keep fighting. As a matter of great concern to medicine's leadership it was generally thought that the national election in November of 1964 was the "kiss of death" to anything except a federally controlled program for the care of the elderly.

But something new has been added to make the stew more flavorful. A more adequate medical, hospital and general care program has been offered—better administered and at less cost—

under state control. The care of the patient and his medical needs are to be taken into consideration rather than the care and treatment of his politics. Dollars and how many will be needed are being counted rather than just the votes that may place people in high office. Eyes are being opened and proofs are available that better than two-thirds of the public don't even know what "Medicare" would provide, let alone how much it would cost. Furthermore, the fact that there can be Better Care than Medicare is being told and fortunately it makes sense to those who will listen for a few moments.

State and county medical societies have inaugurated informational programs to tell the public the truth. How this is being done in Illinois is the subject of a special 24-page section in this issue of the IMJ. I commend it to all members for their reading and close study. The importance of the program to your future practice of medicine should be understood so that you may explain it to any and all who may inquire, especially your friends and patients.



Kidneys and Heart: Glomerulonephritis has been conceived to be based in many cases on an autosensitization mechanism. The production of nephritis in animals by nephritic serum has not been definitely established. One of the obstacles in the experimental approach has been the difficulty of working with identifiable antigens, since kidney substance contains serum proteins, tubular substance, glomerular cells, basement membrane, etc. A sizable contribution to this field was made by Mellors and Ortega¹⁴⁶ when they demonstrated γ -globulin in glomeruli in human glomerulonephritis by employing the fluorescent antibody method. A number of different antibodies have been described in the

serum of patients with glomerulonephritis, but some of the antibodies are also found in other diseases and in normal controls.

A series of 36 patients with clinical acute glomerulonephritis, proved to be due to group A hemolytic streptococcus infection, was followed by serial kidney biopsy by Jennings and Earle.¹⁴⁷ The findings were in accord with progressive changes secondary to the infection rather than as an auto-immune disease.

In a review of the work done on detection of auto-antibodies in rheumatic fever, Kaplan¹⁴⁸ concludes that such antibodies are only presumptive. It is not surprising that heart antibodies were found in the serum of patients with inflammatory or degenerative heart disease.¹⁴⁹ They may be no more significant etiologically than the antibodies found after myocardial infarction, which are certainly the result of the disease. Dressler,¹⁵⁰ however, speculates that the post-myocardial-infarction syndrome may be due to development of antibodies from heart antigen and their interaction.

Cruikshank¹⁵¹ succinctly summarizes this subject. He says that the results of experiments intended to demonstrate a pathogenic role for auto-antibodies in glomerulonephritis, nephrosis and rheumatic fever have thus far only been presumptive. Evidence is increasing that the immunological reactions to bacterial proteins are more likely the immediate cause of the lesions.

Systemic Lupus Erythematosus and Rheumatoid Arthritis: SLE has been regarded as a puzzling syndrome, and accompanied with such a variety of immunological changes as to be suspected of being an auto-immunity manifestation. The finding in 1948 by Hargrave and his associates¹⁵² that leucocytes with inclusion bodies are present in the bone marrow of this

PROGRESS IN ALLERGY

PART 3

OF A THREE-PART SERIES

Samuel M. Feinberg, M.D., Raymond G.
Slavin, M.D. and Alan R. Feinberg, M.D.
/chicago

From the Departments of Medicine, Evanston Hospital, Evanston, Ill., and Northwestern University Medical School, Chicago, Ill.

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disease was soon followed by the demonstration¹⁵³ that these bodies were ingested nuclei and could be best demonstrated by adding the SLE serum to normal leucocytes. This has now become a standard laboratory procedure. It is not always found in all cases and stages of SLE and is found in other conditions frequently, particularly in rheumatoid arthritis. This LE serum factor has been located in a 7-S component of the γ -globulin, having a molecular weight of about 150,000. The LE factor is absorbed by leucocytic nuclei and is not species specific, reacting with nuclear material from rabbit leucocytes or even the nucleated erythrocytes of chickens.¹⁵⁴ The immunofluorescent technique has particularly clearly demonstrated the affinity of the SLE serum for nuclei, and this fluorescence can be shown with virtually all nuclei, human or other mammals, blood or other tissues.

The antinuclear factor is regarded as somewhat different from the LE factor, particularly since the former is located both in 7S and 19S globulins. A number of other antibodies or properties are found in SLE serum, any one patient having differing combinations at different times. Antibodies against erythrocytes are common. Platelet agglutinins are frequently demonstrated and the rheumatoid factor is often found. The Wasserman test is positive in many cases and precipitin tests with DNA are positive. A number of different factors reacting with different components have been found. Antibodies against constituents of the cytoplasm have also been described.

The frequent presence of the LE factor in rheumatoid arthritis and the finding of other SLE auto-antibodies in various other conditions raises the question of the relationship between these syndromes. The role of any of these antibodies in the causation of disease is as yet unknown. It is thought that the presence of these multiple antibodies indicates a defect of immune tolerance involving the antibody-forming cells.

In 1940 Waaler¹⁵⁵ reported that the sera of rheumatoid arthritis patients would agglutinate sheep cells coated with a sub-agglutinating amount of a rabbit anti-sheep cell antiserum. This was designated as the "rheumatoid factor." The procedure has been modified in many ways and a great deal of investigation on it has occurred in the intervening years. Evidence for

the antibody nature of the rheumatoid factor has been presented in a number of ways. One of the most significant is that of Mellors and associates.¹⁵⁶ A fluorescein conjugated antigen-antibody complex specifically stained the rheumatoid factor in the synovial membrane, lymph nodes and subcutaneous nodules, and in every case the localization of the stain was in the plasma cells. The general acceptance of the plasma cell as the site of antibody formation makes the finding of Mellor's group significant.

The diagnostic value of the rheumatoid factor is far from settled, since it is found in other conditions, such as SLE, spondylitis, psoriatic arthritis, and others. The presence of the rheumatoid factor in relatives of the rheumatoid patient has some significance. There is no good evidence that the rheumatoid factor is responsible for RA. The present thinking is that the disease may be on the basis of auto-immunity, the mechanism being probably a delayed hypersensitivity type of reaction. This is supported by the findings of Gitlin and co-workers¹⁵⁷ of the development of rheumatoid lesions in subjects with congenital agammaglobulinemia.

Hematologic: The immunological nature of idiopathic thrombocytopenia has been suspected for a long time. In 1951 Evans and his associates¹⁵⁸ pointed out that since thrombocytopenia is frequently associated with auto-allergic hemolytic anemias the former could also be on an auto-immune basis. Harrington and co-workers¹⁵⁹ produced thrombocytopenia in volunteer subjects given a transfusion of plasma or blood of ITP patients. Tests for platelet auto-antibodies have been developed along different lines: tests for free auto-antibody in the patient's serum or by direct antiglobulin tests on the platelets or by antiglobulin consumption tests. Auto-antibody tests for platelets offer many technical difficulties and are not generally too satisfactory.

In recent years also the possibility of iso-antibodies and auto-antibodies to leucocytes has been suggested by a number of investigators. It is possible that these findings may represent a basis for certain diseases such as leucopenia or agranulocytemia.

Acquired hemolytic anemia is now frequently regarded as an auto-immune phenomenon.¹⁶⁰ It is one of the few suspected auto-immune conditions in which a cytotoxic antibody can

be demonstrated.

Much attention has been turned recently to the possible immunopathogenesis of pernicious anemia. Emphasis in this field has been on three particular associated features in this disease: the atrophic gastritis, the intrinsic factor, and the spontaneous thyroiditis as a frequent accompaniment. As early as 1913 Simmonds described the histological association between lymphoid hypothyroidism and the atrophic gastritis of PA. For many years the association of PA with myxoedema and sometimes with thyrotoxicosis has suggested to many minds a common origin of these syndromes.

In 1959 Taylor¹⁶¹ and in 1960 Schwartz¹⁶² suggested a common auto-allergic component between PA and hypothyroidism. They showed that the serum of PA patients may inhibit absorption of B₁₂ when given together with the intrinsic factor to another patient. Schwartz¹⁶² showed this presumed antibody not to be species-specific and localized to the globulin fraction of the serum. The immunological association with gastric mucosa was demonstrated by Markson and Moore¹⁶³ who showed that in 25% of 52 PA cases a complement fixation reaction was obtained with PA serum and normal gastric mucosa.

The auto-immune relationship between this disease and thyroid is supported by the findings of Irvine and co-workers¹⁶⁴ as well as by Taylor and associates.¹⁶⁵ Irvine's group carried out complement fixation tests against extracts of various tissues removed surgically, including gastric mucosa and thyroid. In PA serum 75% had gastric and 37% thyroid antibodies. In the serum of cases of spontaneous hypothyroidism 22% had gastric and 64% thyroid antibodies. In Hashimoto's disease the gastric and thyroid antibodies were, respectively, 29% and 81%. With other tissues the incidence of antibodies was always less than 4%. The PA antibody was located in the γ globulin fraction. It was interesting also to note that of 14 patients with spontaneous hypothyroidism 5 of the 6 having histamine-fast achlorhydria also had positive complement fixation reactions against gastric mucosa, while none of the 8 who had no histamine-fast achlorhydria gave a reaction.

Auto-antibodies to intrinsic factor and gastric mucosa were examined in 143 PA patients by Taylor and associates.¹⁶⁵ Anti-IF antibodies

were estimated by three techniques: (a) *in vivo* inhibition of B₁₂ absorption; (b) slowing of electrophoretic mobility of IF-B₁₂ complex; and (c) coprecipitation with a radioactive complex of IF-B₁₂. Although all methods correlated the authors regard the electrophoretic methods as the most suitable. Anti-gastric antibodies were determined by complement fixation and immunofluorescence. With the complement fixing method the incidence of reactions was 62%, while with the fluorescence method it was as high as 93% in patients under 60 years of age. By the latter technic the antigen was located in the cytoplasm of the parietal cells.

Other Manifestations: The pathogenesis of ulcerative colitis has had various explanations. These have ranged from the bacterial, psychosomatic, food allergy, and others. More recent developments have hinted at the possibility of an auto-immune mechanism. Bregman and Kirsner¹⁶⁶ found an antibody-like factor in sera from some patients with ulcerative colitis. Broberger and Perlmann¹⁶⁷ showed that the serum from most of 30 children with ulcerative colitis contained a hemagglutinating or precipitating antibody against the extract of the colon of newborn babies. The precipitating antibody appeared to be a γ -globulin. There were some cross reactions with extracts of other tissues and some reactions in control subjects. Antibodies of other cases of ulcerative colitis were studied¹⁶⁸ by immunofluorescence. Out of 13 children 3 were positive by direct test and 6 reacted when tested by the indirect method with conjugates of anti-human globulin. Inhibition tests confirmed the specificity of these reactions.

The possibility that gastritis might be on an auto-immune basis is suggested by the investigation of Hennes and co-workers.¹⁶⁹ Gastric atrophy and an antibody reacting with gastric juice or gastric mucosa of the dog resulted when they were given intradermal injections of autologous, homologous or heterologous (human) gastric juice in Freund's adjuvant.

Endophthalmitis phaco-anaphylactica and sympathetic ophthalmia have long been regarded as auto-immune manifestations. As early as 1903, Uhlenhuth¹⁷⁰ found that lens antigens are antigenic in the host and are organ-specific rather than species specific. In 1921 Woods¹⁷¹ reported anti-uvéal antibodies in perforating in-

juries of the globe. Later he showed that uveal extracts could give an intradermal test in patients with uveal injury. Since then many human observations and experimental investigations have been made. One of the most interesting is the report by Halbert and Fitzgerald.¹⁷² Rabbits injected with lens substance from different species developed cross reacting antibodies to all vertebrate lenses. The lens of the squid, which is an invertebrate, did not cross react. The authors conclude that these findings support the concept that the cephalopod eye and vertebrate eye evolved along distinct lines.

The auto-sensitization mechanism of certain dermatitis cases has been suggested over several decades. The concept holds much attraction particularly for so-called atopic dermatitis (flexural dermatitis, infantile eczema). This syndrome has many earmarks of allergy, such as heredity, the predisposition to subsequent occurrence of hay fever and asthma, the presence of eosinophiles and the frequent presence of skin sensitizing antibodies. Nevertheless, perhaps in the majority of such patients a direct etiologic agent cannot be located. It could be conceived that auto-sensitization to dermal components is the true pathogenic factor, while the circulating antibodies are only the expression of the general immune response (as in thyroiditis, for example). Proof is lacking.

Of 14 patients with chronic dermatitis, Wise and co-workers¹⁷³ found serum globulin in 2 which, when labeled with fluorescein, had an affinity for the dermis in the biopsy specimens of their own skin. Many animal investigations have been made but as a whole the results thus far are inconclusive.

Many pulmonary conditions are of doubtful etiologic origin. Among these are the findings of Balchum and associates.^{174,175} Guinea pigs injected with lung homogenates from animals exposed to noxious gasses (NO_2 , NO and NO-NO_2 mixture) produced antibodies to lung tissue and the lungs showed pneumonitis. However, the morphologic changes did not resemble those of emphysema in man. In studies on human antibodies to normal human lung protein with the latex agglutination technic, they found positive reactions in most patients with pulmonary tuberculosis, emphysema and lung cancer. Those who were tuberculin negative or had pyogenic lung infection had much lower

titers of antibody. They concluded that the specificity of these antibodies was not too great.

A complete authoritative recent text on autoimmunity by McKay and Burnett¹⁷⁶ is suggested to those who wish a complete coverage.

Pulmonary Function

Respiratory function tests may be of use to the clinician in three main ways: 1) to determine whether a subject does in fact have asthma, defined as reversible airway obstruction; 2) to assess objectively the degree of disability present and changes in this degree of disability; and 3) to assess the degree of any other respiratory incapacity. The adequate use of appropriate tests is crucial to any objective assessment of incidence, disability and results of therapy. Respiratory function tests allow an objective measurement of some of the physiologic abnormalities present.¹⁷⁷ Reduction of the volume of air that can be forcibly expired in 1 second ($\text{F.E.F.}_{1.0}$) is the earliest change seen in asthma.¹⁷⁷ Clinically a $\text{F.E.V.}_{1.0}$ /vital capacity percentage of less than 70 indicates abnormal airway obstruction. Measurements before and after bronchodilator aerosol assess objectively whether there is any reversible element in airway obstruction.

It has been known for some years that an impairment may be present in the distribution of an inert gas in patients with asthma when the disease is in remission.¹⁷⁸ Patients recovering from acute or chronic asthma who are asymptomatic and free from wheezing may have a $\text{F.E.V.}_{1.0}$ of one-half that which they can achieve with more prolonged and vigorous treatment.¹⁷⁷ Thus, intelligent use of this test helps prevent undertreatment. It also avoids the prolonged and fruitless treatment of patients with chronic irreversible lung disease with bronchodilators. Read¹⁷⁷ equates the use of long term steroid treatment for asthma without regular spirographic control with treatment of pulmonary tuberculosis without chest X-rays.

The allergist may be faced on occasion with difficult diagnostic problems of respiratory allergy. The history may offer no clear cut seasonal incidence. Skin tests may be of little value for two reasons. First, intense skin reactions may be produced by antigens which are not the cause of the asthmatic attacks and, secondly,

many individuals with asthma do not show skin reactions to allergenic extracts, particularly to foods or drugs. Itkin and his colleagues¹⁷⁹ feel that the best indication of which antigen is most important to the patient is by repeated determination of the F.E.V._{1.0} or other airway function estimate before and after direct respiratory tract challenge. They use an apparatus devised to yield aerosol droplets of such size as will penetrate and deposit deep in the respiratory tract. By repeated quantitative challenge at suitable intervals, it can be learned whether the patient is improving or deteriorating with respect to different treatment regimens or even without treatment. Using phenol red as a tracing agent, one can calculate the amount of the allergen deposited in the respiratory tract by measuring the optical density of a solution exposed to expired air. This permits a correlation of this data with early changes in the behavior of the airways. The significant ratio in their study is per cent change in F.E.V._{1.0}/P.N.U. of antigen retained. In some cases, a positive response to inhalation challenge was obtained even when all routine scratch and intradermal tests were negative.

Often the differentiation between chronic bronchitis and emphysema is difficult. Fletcher and his group¹⁸⁰ have contrasted 2 groups, one, emphysema without chronic bronchitis, and the second, bronchitis without radiologic evidence of emphysema. With the exception of carbon monoxide uptake impairment, many of the clinical and physical changes usually thought to indicate the presence of pulmonary emphysema may be brought about simply by severe airway obstruction due to chronic bronchitis. The authors conclude that the diagnosis of emphysema, implying significant destruction of alveolar tissue, should be made only when the characteristic pattern of functional abnormality is observed or when the condition can be demonstrated radiologically.

Several recently described tests have greatly simplified evaluation of pulmonary function. The Wright peak flow meter which has the advantage of simplicity and portability measures the maximum air flow sustained over 10 milliseconds. The results correlate closely with the standard methods of assessing airway obstruction,¹⁸¹ such as F.E.V. The Campbell rebreathing method for measurement of arterial CO₂

tension involves the principle of equilibration by rebreathing of a bag containing a CO₂-O₂ mixture with the patient's alveolar air. The point of equilibrium represents the CO₂ tension of mixed venous blood which is 6 mm Hg higher than arterial blood. Therefore one can estimate CO₂ arterial tension by subtracting 6 mm Hg from the observed tension. Results agree with direct arterial blood measurements.

A simple test of ventilation-perfusion relationship has been described by Anderson.¹⁸² This involves determination of the end expiratory-end tidal pCO₂ difference by means of infrared CO₂ analysis. This difference was less than 5 mm Hg in a control group with residual volumes of less than 40% of total lung capacity. Differences greater than 5 mm were found in 92% of patients with chronic bronchitis and/or emphysema. Increase in end expiratory-end tidal pCO₂ difference correlates reasonably well with increase in residual volume and decrease in maximum breathing capacity. The author suggests its use as a rapid screening test for abnormal ventilation perfusion relationship.

A relationship seems to exist between lowered blood pH and adrenalin resistance in acute bronchial asthma. The Children's Asthma Research Institute and Hospital group has described a lowered blood pH and elevated CO₂ in association with the most severe forms of status asthmaticus.¹⁸³

The development of a new radioactive Xenon technique allows the determination of the time course of gas distribution over 6 lung zones simultaneously.¹⁸⁴ In 12 patients with asthma in remission, static distribution indices for ventilation and perfusion were the same as normals. In contrast, quantitative analysis of rates of wash-in of inhaled Xenon revealed significant abnormalities of ventilation and these abnormalities were regional rather than diffuse. This regional impairment of ventilation bore a general relationship to the degree of reduction of maximal mid expiratory flow rate. Minor regional differences in ventilation are thus better demonstrated by analysis of wash-in curves of inhaled Xenon than by static ventilation and distribution indices. It seemed likely to the authors that persistent bronchospasm or patchy atelectasis on a lobar or sublobar basis was responsible for zonal ventilatory abnormalities. The results also indicate the presence

of nervous autonomy even among various segments of the same lung.

Steroids in Allergic Disease

Mode of Action: It has long been recognized that the adrenal cortex influences reactions of hypersensitivity. Hormones of the adrenal cortex have been shown to produce some protection to animals from the effects of anaphylactic shock and to influence favorably many allergic diseases in man. Aside from a nonspecific effect on inflammation, little is known about the particular action of steroids in altering hypersensitivity reactions. One possible explanation is offered by Telford and West.¹⁸⁵ In animal studies they showed reduction of tissue 5-hydroxytryptamine, lowered histamine levels, markedly disrupted mast cells and reduced liver histidine decarboxylase by glucocorticoids. The relative effectiveness of adrenal cortical steroids in altering histamine and 5-hydroxytryptamine levels in rat tissues paralleled the clinical effectiveness of the various steroid preparations. They believe, therefore, that the therapeutic effects of glucocorticoids in allergy may be partly the result of an action on histamine metabolism or on the binding mechanism for histamine in tissues.

Newer Methods of Use and Applications: Any physician contemplating long term chronic steroid treatment for a patient must compare the undeniable risks of prolonged steroid therapy with its advantages. A recently proposed dosage schedule for steroids offers some promise of equal efficacy and substantially reduced side effects.¹⁸⁶ This new schedule involves administration of the total 48 hour dosage in a single dose every other day, rather than in divided doses during this same period. In many instances the interval has to be reduced. Adrenal suppression with long term therapy on this schedule seems markedly lessened. A further advantage is that patients on every-other-day therapy for 3-4 weeks, after being on a 3 times a day regimen, may safely stop steroids without further tapering. Our experience indicates that the 48 hour dose is not adequate in the initiation of therapy, nor in those patients who have been on steroid therapy for a long time.

In a further effort to reduce side effects, studies have been performed on methods of ad-

ministration other than systemic. It has been felt for many years that topically administered steroids in the form of aerosols would result in a high local concentration of hormone on the bronchial mucosa and might so effect the relief of asthma, with less of the adverse reactions encountered with systemic therapy. While the major therapeutic effect results from the topical deposition on the mucosa of the tracheo-bronchial tree, there is data to suggest some systemic effect. Forsham quoted by Bickerman¹⁸⁷ observed a 50% average reduction in 17 OH corticosteroid excretion in the urine in 4 subjects receiving inhalation of dexamethasone aerosol. However, minimal doses of cortisone by aerosol have been shown to be more effective than a comparable dose ingested orally.^{188,189} Arbesman reports particular effectiveness of dexamethasone aerosol in children with the extrinsic type of asthma.¹⁸⁹ Bickerman¹⁸⁷ makes the point that while long term administration of dexamethasone aerosol would not seriously impair the functional reserve of the adrenal cortex, any patient receiving prolonged therapy should be given supplemental steroids when subjected to added stress such as surgery, trauma and serious infection. Two recent studies report excellent results with the aerosol form of dexamethasone phosphate in the treatment of ragweed hay fever.^{190,191} We have found anasal spray of dexamethasone effective in obstructive nasal allergy.

The newer corticosteroid drugs such as fluocinolone acetonide, flurandrenolone acetate, triamcinolone acetate, seem to offer greater value in topical therapy.^{192,193} The effectiveness of these preparations is increased when applied under an occlusive plastic film.^{194,195} The beneficial effect observed is probably produced by maceration under the plastic film with the retention of steroid in the treated area.

It is widely felt that initiation of steroid therapy condemns a patient to long term use because of difficulties encountered when the drug is stopped. Franklin¹⁹⁵ has noted a general decline in the need for steroids in patients whose management includes bronchodilators, reduced exposure to allergens, and injection of allergenic extracts. The need for steroids ceased even after several years of continuous steroid treatment. He thus feels that the initiation of steroid

therapy need not be considered an irrevocable step.

Complications: The usual list of complications from prolonged steroid therapy is well known to most physicians. It includes Cushingoid syndrome, gastric ulceration, acneiform lesions, osteoporosis with vertebral collapse, psychoses, fluid retention, systemic hypertension, spread of localized infections including tuberculosis, and aggravation of diabetes or initiation of hyperglycemia. Coagulation times and protamine titration values for heparin are reported to be lower than average in patients with allergic disease, particularly asthma, while steroid and ACTH depress mast cell function and heparin production. The combination is thought to account for the frequent thromboembolic phenomenon noted in severe cases of asthma treated with steroids.¹⁹⁶

Development of chronic glaucoma has been reported in 5 patients following intensive local corticosteroid therapy.¹⁹⁷ This was accompanied by high tension in all cases. The authors make the point that frequent examination of eye pressure should be made in patients receiving prolonged local steroid therapy. In another study, a large number of patients on long term systemic corticosteroid therapy had significant increases in intraocular pressure and mean ocular rigidity.¹⁹⁸

There have been reports of systemic corticosteroid therapy as an etiologic factor in the formation of post subcapsular cataracts.¹⁹⁹ In a large series of asthmatic patients studied carefully, there was no increase in cataracts and the authors conclude that treatment with oral steroids is not likely to cause cataracts in asthmatic patients.²⁰⁰ In our own series of several thousand patients on corticosteroid therapy, many of them for prolonged periods, we have not encountered an instance of lens cataract attributable to the therapy.

The group at the Children's Asthma Research Institute and Hospital has called attention to the reduced linear growth rate in children on steroids²⁰¹. There is also a statistically significant difference in the height between chronic asthmatics and the normal for non-asthmatic children. The difference in growth rate is related to the severity of the asthmatic state. Thus, both an intractable asthmatic state and its therapy with steroids depresses growth, the

asthma effect being more pronounced than the steroids. The reason for this effect of steroids on growth is not known. Szentivanyi and his group measured the incorporation of intra-peritoneally administered S³⁵ labeled amino acids into serum and tissue proteins of adult rats after injection of cortisone. Their results would indicate that depression of growth may be secondary to amino acid deprivation produced by a uniform primary increase in amino acid transport or metabolism by all cells.²⁰² Other studies show that the presence or absence of certain micronutrients such as manganese can modify the effect of cortisone upon growth.²⁰³ Many factors will have to be studied before definite conclusions can be drawn as to the mode of action of these hormones on the growth of children.

Encouraging reports have been received on the use of Stanazolol, an anabolic agent, in accelerating linear growth without comparable skeletal maturation in growth retarded, adrenocorticoid treated, asthmatic children.²⁰⁴

It is well known that steroids lower resistance to infection. However, it must be kept in mind also that infections not infrequently complicate types of diseases treated with adrenal hormones. It should, therefore, be remembered that often the disease per se, rather than hormones used to arrest its progress, enhances susceptibility to infection.²⁰⁵ Attempts to prevent infection with antimicrobials in patients on steroids have not been successful because of the variety of infectious agents involved and the diminution of host resistance so often present.²⁰⁵ Studies in the past²⁰⁶ have recommended use of anti-tuberculous medication in children who are tuberculin positive and antibacterial therapy for pre-existing infection before starting steroid hormones. Others suggest prophylaxis with isoniazid in tuberculin positive individuals or in those with pulmonary lesions even if they appear inactive.²⁰⁵

An infectious complication has been reported with topical corticosteroids and occlusive dressings.²⁰⁷ After initial excellent results 2 patients developed antibiotic resistant secondary staphylococcal infection. The authors feel that the hazard of treating hospitalized patients with occlusive dressings is greater because of the greater prevalence of antibiotic resistant staphylococcal organisms in the hospital.

Some controversy exists with regard to the effect of the "steroid era" on mortality from asthma. Alexander²⁰⁸ and Sheldon²⁰⁹ feel that the introduction of corticosteroid therapy may be responsible for a decline in fatalities from bronchial asthma. Samter,²¹⁰ on the other hand, is of the opinion that corticosteroids have decreased the morbidity but increased the mortality of patients suffering from asthma. Arbesman²¹¹ also believes that more deaths are occurring now in asthmatics and wonders whether changing the pathologic and physiologic picture with steroids might be responsible.

Adjuvants in Antigen Therapy

It is a well established fact that antigens incorporated into mineral oil emulsions, called adjuvants, enhance antibody formation and hypersensitivity in animals. As a matter of fact, with certain antigens aiming at particular immunological states, such as autosensitization, this is the only way by which usually it can be accomplished. Freund and associates²¹¹ introduced this method by incorporating the antigen in mineral oil emulsion with and without tubercle bacilli.

Salk and co-workers²¹² introduced the use of influenza vaccine in emulsion in 1951. This was later elaborated by Davenport and Berlin and their co-workers.^{213,214,215} Using 0.25 cc of an emulsion containing equal parts of influenza virus and a mineral oil-Arlacel mixture, it has been found, in an experience of close to 200,000 inoculations, that antibodies persist for a long time, frequently for 10 years. The use of this preparation was limited to an experimental group, chiefly in the armed forces. Steps are under way, however, to allow a broader use of this form of influenza immunization.

Emulsified Antigens in Desensitization: In 1947 Mary Loveless²¹⁶ reported the first use of a pollen antigen emulsified in mineral oil, indicating that by the use of a large dose of the antigen, and because of slowed absorption, a single dose could replace a series of injections of aqueous extract. Her claims failed to arouse great interest until Brown²¹⁷ published his first report on the subject. Brown first employed the formula of Loveless (mineral oil with Falba), then changed to Drakeol (a special mineral oil) with Arlacel. In his technics he made a number of successive changes, in the preparation of the

extract, in the manner of emulsification, in the mode of injection, and in the pre- and post-injection treatment. Although he has published numerous papers on the subject his experience is perhaps best summarized in a particular one.²¹⁸ The results claimed by him are "as close to 100 per cent as knowledge permits."

The vast majority of allergists have failed to match the enthusiasm of Brown. In 1960 we treated 125 hay fever patients with the "single-shot" emulsion method with a 50% or greater relief in 67%. During that same year we (S.M.F. and A.R.F.)²¹⁹ were co-chairmen of a committee of the American Academy of Allergy, one purpose of which was to study the repository therapy on a national scale. Of a total of 1,777 ragweed patients treated with the emulsion by a group of collaborators 200 received the emulsion without the pollen extract. Seventy per cent of previously untreated patients obtained 50% or greater relief with the ragweed emulsion and 29% with the placebo emulsion. In the previously perennially treated patients 80% had relief after ragweed emulsion treatment and 57% after the placebo injections. The incidence of systemic reactions was 6.5%.

Arbesman and Reisman²²⁰ used either a single or double repository treatment and found a lower incidence of satisfactory clinical response than with aqueous extracts. Sherman and associates²²¹ made a double-blind study, comparing the results in ragweed-emulsion treated patients with placebo emulsion, and also comparing emulsion treatment with the aqueous. The aqueous treated patients fared better than the emulsion treated although the latter had a considerably better result than those given placebo emulsions. The Friedlaenders²²² in a double-blind study did not obtain striking results with ragweed emulsion.

Many other reports have been published indicating varying degrees of success, describing different methods and discussing certain hazards. Because of the great volume of such material we feel that the reader would be served best if we summarized the clinical impressions.

Injections of antigens emulsified in mineral oil can produce some protection against exposure to that antigen. While such a method has an advantage of saving the patient multiple treatments it has also several disadvantages.

The average incidence of results is not as good as with properly given aqueous injections. Occasionally a particular individual may do better with the emulsion treatment.

Hazards of Emulsion Therapy: While constitutional reactions (asthma, urticaria, etc.) can be minimized with proper evaluation of the individual patient and the giving of 2 or 3 separate injections rather than one, they still occur. More important perhaps is the hazard of localized reactions resulting in nodules and sometimes in breaking down of tissue with formation of a sterile abscess. Although it has not been ascertained that the injection of either the mineral oil or the Arlacel can provoke delayed visceral disease, the results of such experimental injections in animals is disturbing.^{223,224,225}

Abscess formation, in the Academy series, occurred in about 0.3% of those injected. Some clinicians have experienced this complication more frequently, some never. Among the possibilities of causes of abscess formation are: superficial injections, impurity of the Arlacel, infection, particular susceptibility of children and Negroes, irritativeness of the antigen, and the delayed sensitivity induced in persons not previously sensitive to the antigen. For example, one group of workers²²⁶ experienced 42 abscesses with mold repository treatment. It is suspected that a large percentage of those who develop an abscess have had no clinical sensitivity nor true immediate bona fide skin test reaction. Unless special precautions are taken to prepare mold extracts with a high degree of freedom from irritants they will frequently give false positive reactions on intradermal testing. It is known that some extracts, such as molds and insects, contain multiple antigens. Even though the patient may have antibodies to some, he may not have them to others. The injection of the latter may be responsible for the induction of delayed sensitivity and abscess formation.

Antigen Emulsions as an Experimental Tool: In our study at a state prison²²⁷ we have induced delayed skin reactivity in a series of non-atopic subjects who were given an injection of an emulsified antigen. Those with the higher degree of induced sensitivity showed gradually developing swellings at the site of the injection

of the emulsified antigen, which in the most severe instances resulted in a sterile abscess. It is significant to note that 6 sterile abscesses in 5 subjects developed when the emulsified pollen antigen was injected in 53 nonatopic persons, whereas out of a series of several thousand injections of emulsified antigens given by us to patients who were spontaneously allergic to the antigen not a single case of abscess occurred.

Immediate skin reactivity was produced by us²²⁸ in nonallergic individuals and in those allergic individuals injected with an antigen emulsion to which they were not spontaneously sensitive. The antibodies had the characteristics of reagin. Connell and Sherman²²⁹ have shown that atopic individuals receiving an injection of emulsified pollen to which they are spontaneously sensitive have an increase in reagin titer. Arbesman and Reisman²³⁰ found an inconstant increase of hemagglutinating titer from repository injections, but the use of a purified fraction of the antigen (ragweed) for coating the red cells increased the titer. Delorme and co-workers²³⁰ found an increase in hemagglutinating titers, but no correlation between the latter and its skin sensitizing or blocking antibody levels. There was no constant relationship between the degree of clinical improvement and the concentration of any of the three antibodies.

The question of injection of antigens in emulsion for protection of the allergic patient is far from a settled one. Admittedly when we inject an animal with an antigen in emulsion or an emulsified virus in man we can expect increased antibody production. But in allergic man we already have antibodies (undesirable ones). We certainly do not wish to increase them, although we apparently do so. Increase in blocking antibodies is not of an order or degree to explain whatever benefit is claimed. In a recent editorial Claman²³¹ poses the question: "Does injection therapy produce tolerance or immunity?" He is inclined to believe that immunological tolerance is the answer, and that this phenomenon requires the frequent injection of antigen. The continued presence of antigen may be met to some extent by the slowed absorption of the emulsified antigen. On the other hand it has been established in experiments on mice²³² that introduction of antigen with adjuvants hinders the production of toler-

ance but favors antibody production. As Claman infers, perhaps the answer is the use of slowly released repositories of antigen in non-adjuvant form.

In closing this section it should be noted that because of the uncertainty of the stability of emulsions such allergenic products are not ready for marketing nor for preparation by the individual physician other than those equipped by training and experience to make the prepa-

rations, evaluate the emulsions by a number of methods, and assay the patient for his degree of sensitivity.

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PRIMARY ADENOCARCINOMA OF THE APPENDIX is uncommon. In 1956, Sieracki¹ reviewed the literature and found fifty cases, to which he added eight more.

He stated that the first case was reported by A. Berger in 1882.

In his review of 50,000 appendices from leading hospitals in the United States, Collins² mentioned 41 primary adenocarcinomas of the appendix. This represents incidence of 0.08%.

In 1962 Wilson³ reported 17 new cases from

several hospitals in Vancouver, Canada. Since that time the following cases have been added to the literature.

Hesketh⁴ in 1963 described six cases, youngest of which was a 17 year old girl.

Two of the cases had metastases at the time of surgery.

Smith⁵ reported a case in which filling defect was seen on x-ray and the diagnosis of adenocarcinoma of the appendix was suspected preoperatively. The tumor recurred and patient died 3 years after original surgery.

Tsardakas⁶ published one case in which the diagnosis of carcinoma was established by biopsy during exploration for a mass in the right lower quadrant. Subsequently hemicolectomy was done.

Two cases have recently occurred in our hospital. Both patients had right hemicolectomy after the diagnosis was established.

ADENOCARCINOMA OF THE APPENDIX

REPORT OF TWO CASES

*Victor R. Jablow, M.D., and
Zenobius Semkiw, M.D./chicago*

Pathologist, VA Hospital, Hines, Ill.: Clinical Assistant Professor of Pathology, University of Illinois College of Medicine.

Pathologist, from the Department of Pathology, VA Hospital, Hines, Illinois.

Case Reports

Case 1: A 38-year-old white male patient was admitted on 8/3/57 because of right lower quadrant pain, vomiting and diarrhea for three days. Past history and systemic review were not contributory. Blood pressure on admission was 130/70, temperature 101°F and pulse 84. The urine contained 1+ albumin. Hemoglobin was 12.5 gm. per 100 ml.; hematocrit 43 per cent; white blood count 15,500 with 77 per cent neutrophils; 11 per cent lymphocytes and 12 per cent band forms. A diagnosis of acute appendicitis was made. At surgery the appendix appeared acutely inflamed and was removed. Postoperatively the patient had several episodes of fever which subsided with the administration of tetracycline. Serological tests for syphilis, done postoperatively, included a cardiolipin microflocculation test which was 3+ and a cardiolipin complement fixation test which was 4+. A complete course of anti-syphilitic therapy was given to the patient. Adenocarcinoma of the appendix was found on microscopic examination of the specimen and he was readmitted a few weeks later for a right hemicolectomy.

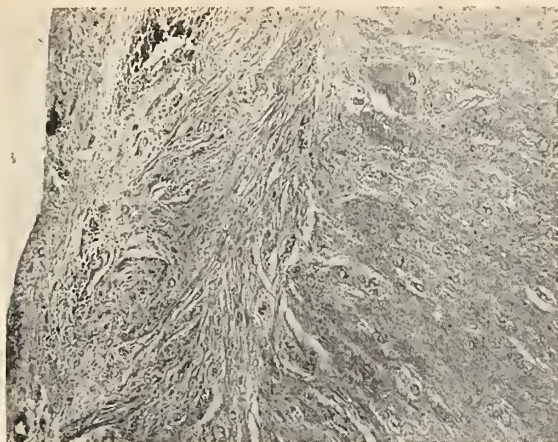


Figure 1. Photomicrograph which shows small glands infiltrating wall of the appendix. Hematoxylin and Eosin, $\times 160$

Pathological report: The specimen consisted of an appendix measuring 8 cm. in length and 1 cm. in greatest diameter. The serosa was covered with hemorrhagic and purulent material. The wall was thickened and the lumen appeared occluded in the distal two-thirds. Its proximal one-third was filled with fecal material. The attached mesoappendix was indurated, hemorrhagic, and contained several small lymph nodes.

Histologically there was an acute suppurative appendicitis. In one section from the middle third of the appendix there were infiltrating glandular structures, containing mucous material (Fig. 1 and 2) which extended through the entire wall of the appendix. The glands varied in size and shape and frequently were lined with rather uniform appearing cells. The mucicarmine positive material was present in the glands as well as in the individual cells. The diagnosis was mucinous adenocarcinoma of the appendix and acute suppurative appendicitis.

The colectomy specimen consisted of the right colon and terminal ileum and, separately, a Meckel's diverticulum. The mucosa of the diverticulum contained a small nodular thickening which on cut surface resembled pancreatic tissue.

Histological examination of sections from the area of previous surgery revealed chronic inflammatory changes and foreign body giant cells. No residual tumor was found. Numerous lymph nodes showed acute and chronic lymphadenitis. The Meckel's diverticulum contained aberrant pancreatic tissue.

The patient was discharged and readmitted for re-evaluation on several occasions. In the last contact with him by letter from the Tumor Registry in April 1964, he was asymptomatic.

Case 2: A 65-year-old white male was admitted in January 1960 because of complaints referable to the gall bladder. He also had a history of chronic bronchitis with recent acute exacerbation. On admission his temperature was 102.5°F. which became normal after his fifth hospital day. The bronchitis was treated with broncho-dilators and antibiotics. A cholecystogram showed a non-functioning gall bladder and cholelithia-



Figure 2. Malignant glands in the mucosa of the appendix. H and E, $\times 200$

sis. It was decided that an elective cholecystectomy would be done after his bronchitis had subsided.

He was readmitted two months later with right upper quadrant distress, nausea, and vomiting. On admission his blood pressure was 110/80, pulse 78 and regular. The chest showed decreased excursions; the lungs were clear to percussion and auscultation. The heart showed normal sinus rhythm. There was right upper quadrant tenderness. The white cell count was 7,000; hemoglobin 15.4 gm. per 100 ml.; a hematocrit of 45 per cent. The urine was negative. An elective abdominal exploration was carried out. The gall bladder and the appendix were removed. Because adenocarcinoma was found on histologic examination of the appendix, a right hemicolectomy was later performed.

Pathological examination: The specimen consisted of a gall bladder and an appendix. The gall bladder contained one stone. The appendix measured 3 cm. in length and 0.7 cm. in diameter. The wall measured 0.3 cm. in thickness. The lumen was barely identified. Fibrous tissue obliterated the tip of the appendix. Microscopically, in the mid-portion and extending through all the layers into the serosa, were numerous glands (Figs. 3 and 4). They were lined with malignant cells which were flattened cuboidal to columnar and contained large amounts of mucinous material. The tumor cells varied in size and staining quality; many nuclei were large and prominent. Lymphoid aggregates in the periappendiceal fat also contained a few tumor glands. In the proximal portion of the appendix there was a small cyst on the serosa lined with tall columnar epithelium containing granular eosinophilic material. The diagnosis was primary adenocarcinoma of the appendix; a subserosal cyst; subacute cholecystitis and cholelithiasis. The colectomy specimen consisted of terminal ileum, cecum and a portion of the ascending colon. The ileum measured 18 cm. and colon 45 cm. in length. The serosa of the cecum contained a few adhesions, but no residual tumor was present. The patient was discharged. He has been followed periodically and was last seen June 1963. No symptoms referable to the abdomen were present.

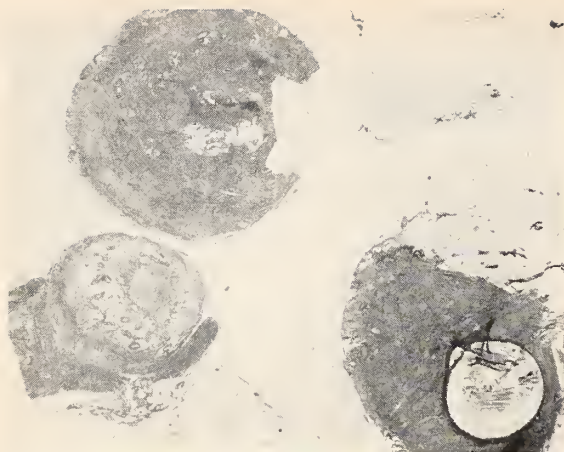


Figure 3. Adenocarcinoma infiltrating the wall of the appendix. H and E x 8

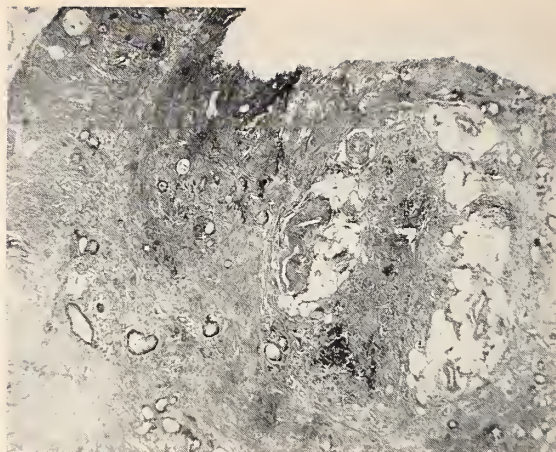


Figure 4. Higher magnification of glands infiltrating muscular layers of the appendix. H and E x 80

Comments

The preoperative diagnosis of adenocarcinoma of the appendix is extremely difficult and almost impossible to make before exploration. Most of the cases reported have been diagnosed as acute appendicitis.

In many instances the diagnosis has not been apparent even at surgery, or when the specimen has been examined grossly.

To be acceptable unquestionably as a primary carcinoma, the tumor should be confined to the appendix without involvement of the cecum. If the tumor involves the cecum it may be hard to decide whether it was primary in the appendix or has extended to the appendix from a primary adenocarcinoma of the cecum.

In the two cases presented, the diagnosis was made only on histological examination. In one case tumor was confined to the appendix and in the other few malignant glands were present in periappendiceal fat. The malignant glands diffusely infiltrated the wall of the appendix.

Summary

Two cases of adenocarcinoma of the appendix are presented. In both instances a right hemicolectomy was performed. The patients are asymptomatic 6½ and 3½ years after surgery.

Acknowledgements

We appreciate valuable suggestions of Dr. Margaret Littman, who reviewed the manuscript, and the technical assistance of Mr. Robert Weiskopf.

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FIGURE 1. Gross section of spleen showing two intrasplenic hemorrhages. The upper one measured approximately 8 cm in diameter and the lower 4 cm.

SPONTANEOUS RUPTURE OF THE SPLEEN WITH SUBACUTE BACTERIAL ENDOCARDITIS

*Richard A. Saavedra, M.D., F.A.C.P.
/oak lawn*

Senior attending Staff, Christ Community
Hospital, Oak Lawn, Illinois

RUPTURE OF THE SPLEEN associated with subacute bacterial endocarditis occurs with sufficient rarity that it was felt worthwhile to report such a case.

Case Report

A fourteen-year-old, white female was admitted to Christ Community Hospital, Oak Lawn, Illinois, on January 6, 1963, because of weakness, weight loss, dysmenorrhea and anemia unresponsive to iron containing medications.

Her past history revealed that she had chicken pox, measles and mumps. There was no history of rheumatic fever, sore throats or recent dental or other surgical procedures.

Physical examination revealed a somewhat pale, white female, who appeared chronically ill. Pupils were round, regular and equal and reacted to light and in accommodation. Ear, nose and throat were unremarkable. There was no evidence of petechiae. The lungs were clear to auscultation and percussion. Examination of the heart revealed an apical systolic murmur of grade II intensity, which did not radiate. The pulse was 100. The blood pressure was 100/60. Examination of the

abdomen did not reveal any enlargement of the liver, spleen or kidneys. The extremities were normal. Neurological examination was unremarkable.

Laboratory data: The hemogram revealed a hemoglobin of 9 g. and hematocrit of 37%. The red blood cell count was 3,530,000. The white blood cell count was 7,200 with 58% segmented neutrophils, 41% lymphocytes and 1% monocytes. Moderate anisocytosis and poikilocytosis were noted. Urinalysis revealed a sp. gr. of 1.017, albumin and sugar were negative. Microscopic analysis revealed 0-2 white blood cells per high powered field. No red blood cells were found. An occasional epithelial cell was noted. Nose and throat culture revealed normal flora. Sedimentation rate was 40 mm. in 1 hour, corrected (Wintrobe method). The total protein was 6.6 g., albumin 3 g., globulin 3.6 g with an a/g ratio of .9. The thymal turbidity was 1.6 units. The serum transaminase was 6 units. The C-reactive protein was negative. The antistreptolysin O titer was 200 Todd units. The total serum bilirubin was .7 mg with .2 mg direct reacting and .5 mg indirect reacting. The cephalin flocculation was 3+ at the end of 48 hours.

Chest X-ray revealed a pleural adhesion at the mid portion of the left hemidiaphragm. The heart and aorta were normal in size and contour.

The electrocardiogram showed a rate of 90 with normal sinus mechanism. The PR interval was .13 seconds and the QRS interval .06 seconds.

Hospital course: The patient ran a low grade fever 99.2 to 99.4°F. Pulse ranged between 110 to 120. No specific therapy was given. She was discharged from the hospital on January 9, 1963, after refusal by the family of further diagnostic procedures. The discharge diagnoses were hypochromic anemia with malnutrition and possible mitral valvulitis.

Shortly after discharge contact was lost with the patient. She was readmitted to the hospital for the second and last time on March 21, 1963 with the history of fainting while engaged in a card game at home. Her mother stated that there was no recent trauma or unusual exertion. The patient had been taking a vitamin preparation in the interim and her mother stated that she had been feeling fairly well. At the time of admission to the hospital, the patient was in apparent shock with a weak and thready pulse and no obtainable blood pressure. Intravenous saline followed by blood transfusions were given. Further examination later revealed slight left lower quadrant abdominal tenderness but no palpable masses or organs. There was no evidence of petechiae.

Laboratory studies revealed a hemoglobin of 5.3 g. and hematocrit of 17%. The white blood cell count was 24,250 with 44% band forms, 34% segmented neutrophils, 1% eosinophiles, 19% lymphocytes and 2% monocytes. Urinalysis revealed a sp. gr. of 1.011, albumen 1+, sugar negative. Microscopic analysis revealed 3-10 white blood cells per high powered field, no red blood cells, 3-5 hyaline and 4-8 granular casts per high powered field. Portable X-rays of the chest and the abdomen did not add anything further to her clinical picture.

Hospital course: The temperature was 102.4 rectally and the pulse ranged between 120-130 per minute. She responded temporarily to supportive measures, however, approximately 12 hours later she went back into shock and expired on March 22, 1963.

Autopsy findings: The peritoneal cavity contained 2000 ml. of partly clotted blood. The spleen weighed 650 g. It was markedly adherent to the left diaphragm over an area of 3 cm. There was a large area of hemorrhage with a capsular tear noted on the surface of the upper pole of the spleen. Cut section revealed two large areas of intrasplenic hemorrhage*, the largest at the upper pole measuring 8 cm. in greatest diameter. The second hemorrhage was located near the mid portion and measured 4 cm. in diameter. Proximal to the areas of the hemorrhage was noted firm yellowish areas suggestive of acutely necrotic splenic tissue. Elsewhere the spleen showed prominent corpuscular markings.

The heart weighed 210 g. The epicardial surface was smooth and glistening. The coronary arteries were patent. There was moderate dilation of the left atrium. The myocardium was firm and light brown in appearance. The valvular measurements were as follows: Tricuspid and mitral 10 cm. each; aortic and pulmonary valves 6 cm. each. There was some shortening of the chorda tendinae of the mitral valve. The superior aspect of the mitral valve leaflet on the posterior portion showed small grayish vegetations. This involved approximately two thirds of the valve leaflet and extended onto the wall of the left atrium in the posterior aspect. The largest dimension of this patch of vegetation measured 3 cm. in diameter.

Microscopical analysis revealed the myocardium to show foci of interstitial lymphocytic infiltration. Sections through the mitral valve revealed subendothelial thickening due to fibrin and organizing granulation tissue. There were numerous lymphocytes and neutrophils. Small bacterial colonies were noted on the surface of the valve. These were for the most part made up of cocci arranged in small clumps and short chains.

The spleen showed large areas of hemorrhage. There were also seen large areas of necrosis with peripheral organization. There was hematoidin pigment in the necrotic and organizing areas. Some of the arteries in the necrotic foci were filled with a fibrinopurulent debris. The red pulp was congested with thickening of the splenic pulp cords.

The glomeruli of the kidneys showed focal necrosis and hyalinization. Other glomeruli showed diffuse hyalinization with fibrosis both capsular and intraglomerular in location. The interstitial zones showed focal lymphocytic infiltration.

The pathological diagnoses were:

1. Subacute bacterial endocarditis, mitral valve leaflet and left atrium, superimposed upon rheumatic mitral valvulitis with mitral insufficiency.
2. Massive intraperitoneal hemorrhage, secondary to ruptured spleen.
3. Congested spleen showing areas of hemorrhage adjacent to organizing infarcts, the latter most likely due to embolization from infected mitral valve.

4. Focal glomerulonephritis secondary to subacute bacterial endocarditis.
5. Focal chronic myocarditis.

Discussion

On review of the literature this is found to be the thirteenth reported case of spontaneous rupture of the spleen associated with subacute bacterial endocarditis.

It is surprising that splenic rupture does not occur more frequently in bacterial endocarditis, for splenomegaly is present in 66% and splenic infarcts in 40—60%.¹ Of the twelve perviously reported cases the rupture resulted in death in all but two cases. Wood and Hall² reported a case treated successfully by splenectomy. In the other case, reported by Lockwood,³ the spleen was successfully removed, however, the patient expired nearly a year later of congestive heart failure following surgical evacuation of a retroperitoneal cyst of unknown etiology. The specific diagnosis of splenic rupture due to bacterial endocarditis was made during life only in the case reported by Wood and Hall.² In three of the reported cases,⁴⁻⁶ the patients succumbed to suppurative peritonitis following rupture rather than massive intraperitoneal hemorrhage.

It is interesting that in the present case the patient did not complain of abdominal pain referable to the splenic infarctions or rupture. This has been an almost universal symptom among the previously reported cases. The pain

is usually severe and abrupt, often referred to the clavicles or left shoulder. Splenic rupture may occur in two stages. At first the pulp is lacerated and the hemorrhage is encapsulated. As bleeding progresses the splenic capsule tears and produces massive hemorrhage. Very slight trauma such as over enthusiastic palpation, cough, or sudden positional change may precipitate hemorrhage.

Summary

A case of spontaneous rupture of an infarcted spleen secondary to subacute bacterial endocarditis resulting in death due to massive intraperitoneal hemorrhage is reported in a fourteen year old girl. The rarity of this complication is evident as this is only the thirteenth reported case in the literature. The lack of history of pain due to the infarction and hemorrhage is noteworthy.

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MEDICARE

During the past few years, Canada has been the scene of a number of unusual developments in the financing of medical services and health care—government payment of hospital costs for all residents, free medical services for children under 16 in one province and, an internationally known compulsory government program which pays for all medical services provided to residents of the province of Saskatchewan. These developments have occurred in a country which is in many ways very similar to your own.

Canada is a federation of provinces as your country is a federation of states. By the terms of federation, certain fields of interest are reserved for provincial authority and others are the sole responsibility of the federal government. Health has always been a provincial responsibility.

TRENDS TOWARD GOVERNMENT MEDICINE IN CANADA

B. E. Freamo

Secretary, Medical Economics,
Canadian Medical Association.

Presented before the ISMS Legislative Conference, November 8, 1964 at the Drake Hotel, Chicago.

Traditionally, in Canada, the private practice of medicine, in hospital and out, has been performed on a fee-for-service, private enterprise basis. Our hospitals are almost all public general hospitals, with very few proprietary or private institutions. Except for university centres, the vast majority of our hospitals are open to all doctors who qualify as members of staff.

Governments in Canada have traditionally been active allies of the profession, providing public health services and the specialized treatment of tuberculosis and mental illness. Governments have traditionally relied on private practitioners to provide personal health services.

For many years, all levels of government—municipal, provincial and federal—have made substantial contributions to the cost of hospital construction and maintenance. The effect of this was a subsidized daily rate, roughly half the true cost. The net cost to patients was still sufficient to engender a tremendous interest in Blue Cross and private hospital insurance contracts. This interest also carried over to the cost of medical services and today about 63 percent of our eligible population is insured by private voluntary insurers.

With this background, why have these developments—government payment of hospital costs, free medical care in Newfoundland and Saskatchewan—occurred? Have Canadians become die-hard socialists or are Canadians, individuals who quietly acquiesce to political pressures? I would answer 'No' to both these questions because the reasons are much more complex. Some of these reasons illustrate the differences between our two countries.

First, the hospital story. Our general hospitals were always hard-pressed to finance mounting deficits. The care of the indigent became a costly item and some municipalities were less munificent than others. Municipal governments looked for assistance from the next more senior

level of government. Provincial governments, faced with insufficient revenues to meet rising expenditures, began to court federal financial assistance in the health field.

The federal government, with a treasury buoyed up by inflation and the increased economic activity of the post-war period, was willing to share in the cost of operating hospitals but was unwilling to revise the taxation structure to provide the provinces with taxation powers equal to the cost of their constitutional responsibilities. The result was an extension of grant-in-aid legislation which authorized contributions by the federal government "in respect of programs, administered by the provinces, providing hospital insurance and laboratory and other services in aid of diagnosis."

Under the Hospitalization Act, the federal government pays approximately one-half of the total cost. The provinces pay the rest. Unfortunately, the rate of Canada's economic growth has declined since 1957 and today all provinces have major problems in financing their share of hospital costs. Strict budgetary controls have been introduced in some provinces and we are currently travelling that short but dangerous distance between a situation wherein those funds are provided which are necessary to meet the requirements of the service, and the resultant situation wherein that level of service is provided which can be paid for within a relatively fixed budget.

Unfortunately, sufficient time has not elapsed to make this development apparent to the public. It is however apparent to those involved in hospital administration and conflicting attitudes are developing between those who are inclined to rebel against the controls, and those who feel that the present state of affairs, although undesirable, is better than the situation which existed prior to the introduction of the program.

Time alone will provide the answers to these conflicting viewpoints. I personally believe that within five years, the inevitable extension of controls which rising hospitalization costs will bring about, will convince the general public that they should not accept the blandishments of those politicians who are selling the idea of 'free' medical care.

The proponents of 'free' medical care in my country fall into two groups. First, we have a socialist-oriented group of politicians whom I

believe want to control doctors and the practice of medicine. In Saskatchewan, chance, political opportunism and our particular type of democratic government, combined to allow them to implement their program.

In Canada we do not have the system of checks and balances which is inherent in your legislative process. A government is elected to power when it secures a working majority of elected representatives in the legislature. It has a maximum tenure of office (unless re-elected) but no minimum. The life of the government ceases when it fails to command a majority to support any government-sponsored bill.

In theory any member of the House may propose legislation. In practice, however, any but the most innocuous bill must be government-supported to obtain majority approval.

This tradition is ensured by the application of a stringent form of party discipline. To vote against your party in any vital matter, is tantamount to political suicide.

This places the real power of Parliament in the hands of the Cabinet which bears only a superficial resemblance to your Executive Branch. Each Cabinet member is an elected member of Parliament and, with rare exceptions obtained his post because he is an important and influential member of his party. The Cabinet operates very much like the Board of Directors of a large corporation. Subsequent to making its decisions, measures which it chooses to sponsor are referred to a caucus of its elected supporters to gauge political implications. Party discipline then ensures a majority vote to enact the necessary legislation.

In Saskatchewan this power of decision rested with one man—a situation not uncommon in Canadian politics. Premier Douglas had led his socialist party to power in 1944 and in the ensuing years he had personally been responsible for their continued re-election. A dedicated performer and a gifted orator, he led Saskatchewan into Canada's first experiment in socialism and the force of his personality was such that he survived many political disasters without defeat.

Canada, like the United States, has traditionally had a two-party system. Two splinter groups have arisen over the years—the C.C.F. brand of socialism which Mr. Douglas was implementing in Saskatchewan, and a Social Credit

party—mainly conservative but with “funny money” ideas—which had gained a foothold in Alberta and British Columbia. These parties had, however, never been able to achieve national prominence.

In 1960 organized labour in Canada decided to enter the political field. They chose Mr. Douglas's C.C.F. party as the vehicle and they re-named it the New Democratic Party. They picked Mr. Douglas as their national leader and adopted the “planned economy” as their party platform—a platform which Mr. Douglas had been assiduously implementing in Saskatchewan. They decided that ‘free’ medical care should be the next milestone on their way to a planned economy.

October 1961 was to be the time of Mr. Douglas's assumption of his new role as national party leader. He set out almost two years previously to introduce his medical care program in Saskatchewan. He needed a successful provincial plan in Saskatchewan as a spring board to national success.

Unfortunately for Mr. Douglas, events did not quite keep pace with his timetable and his legislation was not passed until a few weeks after he had resigned as Saskatchewan's Premier. However, his determination to achieve his purpose left a legacy which his successor was committed to implement, and this set the stage for the crisis which followed.

Since this crisis we have had an election in Saskatchewan and a free enterprise government has replaced the socialist planners. However, typical of any government's attitude toward an established welfare program, very few changes have been made in the operation of the Saskatchewan Medical Care Plan.

The second group of proponents of ‘free’ medical care in my country is more numerous, more articulate and more successful in selling their point of view to the public. Typical of this group are the members of the Royal Commission on Health Services which recently published a voluminous report after an intensive 2½ year study of the whole field of health care.

This study, which detailed many of the deficiencies, present and impending, in our health facilities and manpower requirements, made a number of important recommendations with which we substantially agree. As a matter of fact one of our committees is meeting with the

Prime Minister and members of his Cabinet within the next week urging early implementation of legislation to expand the existing facilities for medical education and research.

The same report, however, examined the field of health insurance and, because of the imperfections which they saw in the voluntary system, recommended that it be scrapped and be replaced by a compulsory government controlled program. This recommendation is one with which we disagree very strongly.

I think it is important, however, that we be aware of the arguments which the Commission put forward to support their recommendations.

First their philosophy, they state:

1. “We accept the statement of Sir Arthur Newsholme:

‘Civilized communities have arrived at two conclusions, from which there will be no retreat, though their full realization in experience has nowhere been completely achieved.

‘In the first place, THE HEALTH OF EVERY INDIVIDUAL IS A SOCIAL CONCERN AND RESPONSIBILITY; and secondly, as following from this, MEDICAL CARE IN ITS WIDEST SENSE FOR EVERY INDIVIDUAL IS AN ESSENTIAL CONDITION OF MAXIMUM EFFICIENCY AND HAPPINESS IN A CIVILIZED COMMUNITY.’”

2. “. . . The field of health services illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other.”
3. “What the Commission recommends is that in Canada this gap be closed. That as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind. All our recommendations are directed towards this objective. There can be no greater challenge to a free society of free men.”

Secondly, their method:

They have proposed a ‘service’ plan concept

covering all medical services. Every resident would be covered on a compulsory or automatic basis. Every doctor would be a participating physician. There would be one administrative agency in each province responsible to government. Each doctor would submit his accounts to this agency. He would be paid directly by the agency and the amount of payment would represent full and final payment for every service. Payment would be made on the basis of a fee schedule which would be negotiated by the government agency and the profession.

Third, their arguments against voluntary insurance:

They stated that reliance on the method of voluntary insurance would be unnecessarily slow and inevitably incomplete. They did not accept the proposal put forward by the profession and the insurance industry, that a system which provided for subsidies to low income groups, would result in a situation wherein the great majority of Canadians would insure themselves on a voluntary basis.

They considered that the number of individuals who would require subsidy would be so large that no government could impose the means test procedure on so many citizens or would be justified in establishing a system requiring so much unnecessary administration.

Fourth, their financing—

They stated that the country could afford an overall program providing virtually all health services and that the resulting costs could easily be provided from increasing government revenue, which will be generated by future increments in our Gross National Product. They considered that Canadians would accept an arrangement which converted their present cash or premium outlays on health care into taxation.

Now these proposals and their arguments are completely unacceptable to you and to me but I can assure you that they have great political appeal. The proposals have been accepted by the leader of our federal Conservative party and the present federal government is obviously studying the report intently, prior to establishing policy.

Now what are the chances that this report will be implemented? Will you in the near future see a widespread application in Canada of a Saskatchewan-type plan?

I hope not. There are other concurrent developments in Canada which suggest that the voluntary system will emerge as the method of choice. But, next year is likely to be a federal election year, and one cannot rule out a situation wherein both major political parties would support the implementation of this Royal Commission report for purposes of election strategy. If this happened the medical profession could well become the meat in the sandwich.

However, I mentioned other concurrent developments in Canada. The most important of these has been the re-emergence of our provinces as important political entities. During the last two years, during which you have seen a trend toward further centralization of power in your federal government, we in Canada have seen a de-centralization of power, particularly in those constitutional areas wherein the provinces have the prime responsibility.

Health is one of these areas and we are encouraged by the actions and interest which most of our provincial governments have displayed in the field of medical services insurance. For example the government of the Province of Alberta has publicly repudiated the health insurance recommendations which the Royal Commission proposed. Alberta has a program called the Alberta Medical Plan which within one year's operation has achieved on a voluntary basis, more than 80 percent coverage of their population.

The Alberta Medical Plan has a number of interesting innovations that go a long way toward overcoming criticisms of voluntary forms of insurance. First two standard plans have been devised which every insurer in Alberta must make available to anyone who requests coverage. A maximum premium has been agreed upon by the insurers. No one may charge in excess of this maximum premium rate. Because of this maximum premium, a pooling arrangement has been set up by the insurers, which charges back to each on an equitable basis, the losses which arise from coverage of high risk persons.

The Alberta government is an active participant in this program through the provision of subsidies to low income groups. These are not based on a means test but rather on an income test. Alberta residents whose income is such that they do not pay income taxes are eligible

for a subsidy of about half the premium cost. Those whose incomes are just above the income tax yardstick qualify for a reduced subsidy and of course, those who are completely indigent are provided with medical services without cost under another program.

This plan has been working extremely well. We understand the government is considering the possibility of increasing the amount of subsidy provided to the non-tax-paying group. If this becomes a reality Alberta's program will provide medical insurance to low income earners at less cost than the equivalent group is required to pay, in direct and indirect taxation, in the province of Saskatchewan.

I think that this is a very telling point. What we are really trying to do is to assist low income persons to buy medical insurance through the provision of subsidy in depth to those who really need it. If our proposal provides coverage at less cost to the individual who needs help, than the Saskatchewan plan costs him, then I believe that we can sell a voluntary approach to the public.

Two other provinces have committees studying this problem and we are hopeful that they will adopt programs similar to Alberta's. One

of these provinces is Ontario, our largest province, and its decision will likely set the pace for the remainder. These are the reasons for my optimism about the future of our voluntary system.

Mr. Chairman and gentlemen, these are our current legislative problems in Canada. They are not our only problems. Currently the medical profession is engaging in a searching self-analysis of our attitudes towards insurance and insurance agencies. A special meeting of our General Council will be held in January to consider the recommendations of a number of special committees which have been studying our current policies. I would commend for your reading the reports of these special committees which were published as a special supplement to the September 19th issue of the Canadian Medical Association Journal.

I hope that my remarks have conveyed to you that the medical profession in Canada is actively trying to avert the trend to government controlled medicine in Canada, and that we are endeavouring to influence the governments of our provinces to make their participation more effective, by strengthening the position of the voluntary insurance system.

UNIVERSITY ENROLLMENTS

College and university enrollments last fall soared to more than five million, the Office of Education, U.S. Department of Health, Education, and Welfare said today.

Students working toward bachelor or higher degrees numbered 4,988,000 at 2,135 institutions. Another 332,400 pupils, 60,600 more than last year, are enrolled in special one, two, and three year programs equipping themselves for employment. Most of the work in these latter programs is not creditable toward a bachelor's degree.

Degree credit students entering college for the first time increased 17 percent in contrast to an average rise of approximately 7 percent annually for the past 12 years. These students totaled 1,235,000 as compared with 1,055,000 a year ago. First-time students are freshmen with no prior college.

The jump in first-time enrollments reflects significantly the impact of post-war babies who are now reaching college age. This impact is expected to be just as great next year.

COMMITTEE REPORT

SINCE THE CLOSE of World War II the Illinois State Medical Society has insisted that the Department of Registration and Education provide adequate enforcement of the Medical Practice Act. Complaints by county medical societies and individual physicians have been heard for years. Especially were there disquieting observations made when the registration fees were raised and inadequate enforcement procedures continued because of lack of budgeted departmental funds.

More recently the Department of Registration and Education has proceeded to fulfill the "letter of the law" with regard to enforcement of the Medical Practice Act. The ISMS's House

of Delegates has always been on record in support of this procedure, but in the intervening 20 years the profession itself has allowed unauthorized persons to take advantage of the lack of enforcement. Fortunately, patient care has not suffered as a result.

Arrangements also have been made by hospitals to provide 24-hour emergency care and treatment. In the past two years, since the passage of the state law which makes this necessary in both medical and injury cases, it has apparently proved to be a hardship in some areas to have staff on 24-hour call. Thus, because of weak enforcement procedures some individuals trained as physicians in other nations, but not necessarily for licensure in Illinois, have been assigned duties for which they may not have been licensed. A recent check on the number of individuals in Illinois working under circumstances other than full licensure led the Department to pursue the course of action so frequently elicited and given approval by organized medicine. A number of complaints now have been lodged with the ISMS and the IHA regarding action by the Department to remove these individuals from the potential illegal practice of medicine.

If the present law is not reasonable, then the medical society may seek to change the provisions of the Medical Practice Act. On the other hand, neither the profession, nor the legislators can afford to wink at proper qualifications for those who would treat patients in Illinois. If training and licensure is imposed upon all of us who are members of our medical societies, and if it is still one of the basic purposes of organized medicine to educate the profession in the practice of medicine and surgery, then we must endorse the functions of the Department, and particularly its actions in the enforcement of the present law.

ENFORCEMENT OF THE MEDICAL PRACTICE ACT

Philip G. Thomsen, M.D./chicago

Chairman, Medical Examining Committee,
Illinois State Medical Society.

It behooves the medical staffs of all hospitals affected by the enforcement of the law to carefully examine their desires to continue unauthorized and unlicensed individuals to render patient care under circumstances other than very close medical supervision. Responsible hospital administrators and chiefs of medical staffs should be ever mindful of their joint responsibilities in this most important service to the public. Arrangements to utilize the services of well-trained and capable persons, even though

not licensed, can continue to be made within service areas of hospitals not concerned with diagnosis and treatment of patients in the interest of good patient care. As chairman of the Medical Examining Committee, I suggest that proper care should be taken so that no one individual or hospital staff becomes liable because of irresponsible decisions made in the interest of those who may desire the law, but fail to realize its importance to the people and to the medical profession.

Musical Treat Slated For Annual Convention

HENRI NOEL, BARITONE

BARBARA NOEL,
MEZZO SOPRANO



Mr. Noel

Featured performers at the Annual Banquet of the Illinois State Medical Society on Tuesday, May 18th will be HENRI NOEL, a baritone who is a featured singer from the Chicago Lyric Opera Company, and his partner BARBARA NOEL.

HENRI NOEL has appeared throughout the United States as a featured singer with such companies as the New Orleans Opera House Association, the Mobile Opera Company, the Florentine Opera Company of Milwaukee and many others. In addition to his opera work, he has appeared in many touring Broadway musicals.

In their presentation for the Illinois State Medical Society they will combine popular music, Broadway show tunes with the semi-classical and classical. HENRI's rich voice has often been compared to that of EARL WRIGHTSONS and his partner, BARBARA NOEL's, to that of LOIS HUNT. Together they have appeared at leading hotels, pleasing those who like good popular songs as well as those who enjoy the more serious music.

The View Box

LEON LOVE, M.D.

*Director, Diagnostic Radiology
Cook County Hospital*

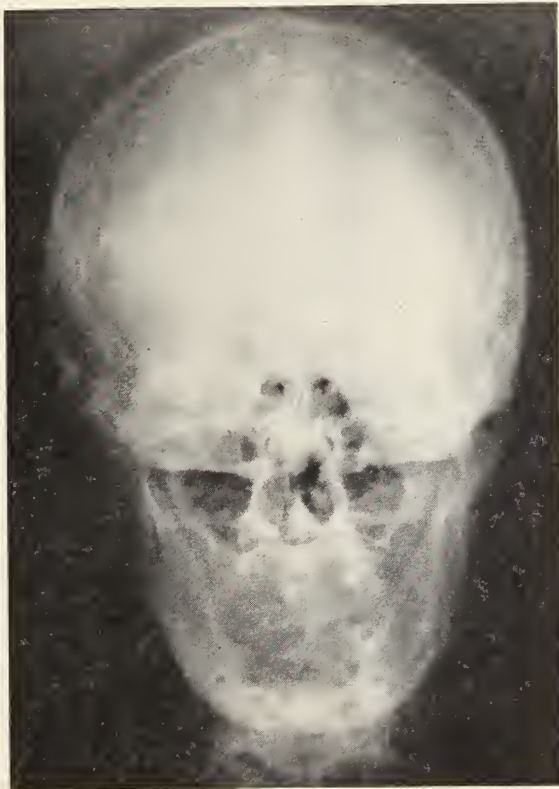


FIGURE 1

This 25-year-old male entered the hospital with a history of weakness of the right upper extremity which increased to complete paralysis. He had some numbness of the left upper extremity and slight dragging of the right foot.

Physical examination revealed a marked weakness of the right upper extremity and spasticity of the left upper extremity. He had bilateral positive Babinski signs and a positive right Hoffman sign. Bilateral ankle clonus was present.

What is your diagnosis?

- 1) Meningeoma of the sphenoid ridge
- 2) Neurilemmona (Neurinoma) involving C², C³, C⁴.
- 3) Multiple myeloma
- 4) Epidermoid cyst

(Answer on next page)

The View Box

—diagnosis and discussion (Continued from preceding page)

Diagnosis: Neurilemmona involving C², C³, C⁴.



FIGURE 2



FIGURE 3

On the AP view of the skull (Fig. 1) note the destruction of the right pedicles of C², C³, and C⁴. On the lateral cervical spine film (Fig. 2), a marked increase in size of the intervertebral foramina with thinning of the posterior border is noted, best demonstrated on the oblique study (Fig. 3).

Bone changes on the plain spine radiographs are four times as common in neurinomas as in meningiomas. They are extramedullary, intradural lesions. Enlargement of the vertebral

canal, erosion of pedicles, increase in interpediculated distances, scalloping of the posterior margin of the vertebral bodies, and thinning of the laminae are changes frequently encountered.

Neurinomas, while remaining encapsulated, may extend out of the vertebral canal with the spinal nerve root and also from the paraspinal area. Such dumbbell neurinomas usually enlarge the intervertebral foraminae.

REFERENCE PAGE #48

LOCATION
OF
ARTIFICIAL
KIDNEYS
IN ILLINOIS

The following is a revised list of hospitals
having an artificial kidney available at this time:

Edgewater Hosp.
5700 N. Ashland Ave.
Chicago 26, Illinois

Phone: Uptown 8-6000
Person in charge: Dr. Rogelio Riero
Location in hospital: Surgical Dept.

Michael Reese Hosp.
29th & Ellis Ave.
Chicago 16, Illinois

Phone: Calumet 5-5533
Person in charge: Dr. Samuel Zoltzman
Location in hospital: Dept. of Internal Medicine

Mount Sinai Hosp. of Chicago
2750 West 15th Place
Chicago 8, Illinois

Phone: 277-4000
Person in charge: Dr. Abraham Chervony
Location in hospital: Dept. of Medicine

Passavant Memorial Hosp.
303 East Superior St.
Chicago, Illinois 60611

Phone: Whitehall 4-4200
Person in charge: Dr. Francesco Del Greca
Location in hospital: Clinical Research Dept.

REFERENCE PAGE #48 (CONT'D)

Presbyterian-St. Luke's Hasp.
1753 West Congress Parkway
Chicago 12, Illinois

Phone: SEeley 8-4411
Person in charge: Dr. Robert M. Kark
Assistants: Dr. Muehrcke, Dr. Pollak, and Medical Renal
Resident
Location in hospital: Renal and Nutrition Dept.

University of Chicago Hospitals
and Clinics
(Bob Roberts Hospital)
950 East 59th St.
Chicago, Illinois 60637

Phone: MUseum 4-6100
Person in charge: Dr. Ardis R. Lavender
Location in hospital: Dept of Medicine

Decatur and Macon County Hospital
2300 N. Edward St.
Decatur, Illinois

Phone 429-2911
Person in charge: Specially trained Staff Physicians
Location in hospital: Special Care Unit

Evanston Hsp. Association
2650 Ridge Ave.
Evanston, Illinois

Phone: UNiversity 9-2500
Person in charge: Dr. Bernard Adelson
Location in hospital: Intensive Care Unit

St. Francis Hsp.
530 Northeast Glen Oak Ave.
Peoria, Illinois 61603

Phone: 674-7731
Persons in charge: Dr. Schlicksup, Dr. Offen & Mr. Myers
Location in hospital: Intensive Care Unit

Swedish-American Hospital
1316 Charles St.
Rackford, Illinois

Phone: 968-6898
Person in charge: Jahn Drew, R.N.
Location in hospital: Surgery Dept.

Memorial Hsp.
First & Miller Sts.
Springfield, Illinois
St. Jahn's Hospital
701 E. Mason St.
Springfield, Illinois

Phone: 527-7575 (day or night)
Person in charge: Dr. Richard Herndon

In addition to the above hospitals in Illinois, we have also received information that the following hospital in Missouri has an artificial kidney:

St. Francis Hsp.
825 Goad Hape St.
Cape Girardeau, Missouri

Phone: EDgewater 4-4461 (Hospital)
EDgewater 5-8241 (Office)
Person in charge: Dr. L. R. Seabaugh, Urologist
Location in hospital: Operating Room (Third Floor)

Although the above hospital is located in the state of Missouri, it may be more accessible in some emergencies than those in Illinois.

It is recommended that the above list of hospitals having artificial kidneys be made available to your personnel for quick reference in emergencies which may require this type of treatment.

EDITORIALS

WHAT ABOUT OUR "IMAGE"?

Late in September, we were watching the "Ed" Sullivan show on T.V. Very proudly, and with a great puff by "Ed", a comedian by the name of Alan King took off on the "doctors." To me, what he said, by and large, was not funny—and sometimes it hurt. Why? Well he hit the spots in the patient's view where unthinking and insensitive doctors often cause such discomfort by their actions and upset the patient. He went after the apparent sacredness of the golfing Wednesdays and Sundays—stating that if you wanted to find a doctor on those days, look in the sand-trap. He hit cold examining rooms, uncomfortable furniture, old, worn out magazines, and other current complaints about doctors and their offices, and really painted a pretty bad picture of our profession, by giving the overall impression that we were a callous group of individuals. What was the audience reaction to all of this? Why they loved it, because in their minds King was giving them an image of their doctor.

In the January, 1965 issue of *MEDICAL TIMES* two papers, "A Moral Concept of the Practice of Medicine" and "Doctor, It Hurts" discuss our diminishing reputation as a profession and why this is happening, because of the fundamental changes in the philosophy of many practitioners of the ART relative to the practice of medicine.

In the first paper it is pointed out that we exist only because people need us. People are not perfect, but we must treat them irrespective of the trouble they may cause us because they are sick (or not sick). We must do this with the thought in mind that we will treat them in the way we would like to be treated or have our family treated. We must be honest in all our dealings and be strong enough to always have the patient's best interests in mind. We must strike down the idea of "You scratch my back, and I will scratch yours." We must not be dishonest to ourselves.

Furthermore, we must not disparage our col-

leagues. Otherwise we become malicious gossips who degrade our profession. You may not honor, and may not like a colleague, but keep your mouth shut about it in the presence of patients. Do your talking, if talk you must, before the disciplinary committee of your local society.

We must give service over and beyond what tradesmen give. The other day we heard a very intelligent woman say: "A year ago when a pipe froze and broke and water was all over the garage, I called the plumber and even though it was Sunday he was there in ten minutes, but two weeks later when my husband broke his leg falling off a ladder, I couldn't find our family doctor and the only advice I could get was to take him to the emergency room of our local hospital." An episode like this doesn't help your image or my image, doctor! When we don't carry out our traditional function of responding to the suffering of man, our profession goes downhill.

It must be remembered that one of our most treasured (and widely talked about) privileges in our profession is the physician-patient relationship. Anything we do to degrade it brings about a growing dissatisfaction with our profession. We must not say one thing and do another. Even with the quantity of patients which we have to serve, we must do our level best to protect and foster the physician-patient relationship. If we maintain it at a high level, we will never have to worry about a system of medicine so ineptly called "Socialized Medicine." Our patients will see that we are not saddled with it.

We must remember that what patients want, as it pointed out in the second paper "is good medical care when and where it is needed." If they get that, our image will never be endangered. But in our odd and unthinking ways we often do things which the patients feel decrease the value of our care in their eyes. We don't

Editorials *(Continued from preceding page)*

make house calls, we don't go out easily after hours, we make patients wait, we tend to be patronizing to patients, and we do many other things which bias patients against us.

While there is little questioning the fact that we take far better care of our patients than

did physicians fifty years ago, we seem to have lost our reputation for humanitarianism. We must be prepared, as Jenkin Lloyd Jones said sometime ago at a Public Relations Institute sponsored by the A.M.A., "like the fire department, to answer all alarms."

Pervin H. Long, M.D.

Reprinted from Medical Times

January, 1965

DIETARY SUCROSE AND CORONARY THROMBOSIS

Yudkin and Roddy¹ of the University of London demonstrated for the first time that the diet of patients with occlusive atherosclerotic disease is different from that of normal individuals. They found that those with coronary or peripheral artery disease had a sugar (sucrose) intake nearly twice as high as that in a control group. In patients with peripheral arterial disease the degree of atherosclerosis was directly proportional to the intake of dietary sugar.

The authors admit the limitations of assessing dietary intake but found it easier to estimate the consumption of sugar than the fat of meat. Approximately half is taken as pure sugar and easily measured in terms of lumps or spoonful. The remainder is taken in readily identifiable foods. They found that the amount consumed by an individual could serve as a predictor of his chance of developing a myocardial infarction. They went so far as to say "Put more simply, we should say that people who take a lot of sugar—for example in their tea or coffee—are far more likely to have a heart attack than those who take little."

The authors did not omit dietary fat and serum cholesterol from their discussion. They

were unable to find reports in which a relationship was noted between the levels of the cholesterol and of any of the dietary constituents including fat, animal fat, and total carbohydrates. References along this line included the report of Oglesby Paul and his group who studied the diets of nearly 2000 men in a prospective study in Chicago. Mention is made of Paul's observation that subjects who developed ischemic heart disease drank significantly more cups of coffee than the control subjects. Yudkin's only comment was that the amount of coffee drunk was perhaps an indication of higher intake of sugar.

This study demonstrates again that the etiology of atherosclerosis is not fully understood and that in all probability many factors play a role. The least of which might still be dietary. It is unfortunate that the study neglected to correlate these other factors including estimates of fat and protein in the diet, weight, blood pressure, and serum cholesterol.

Theodore R. Van Dellen, M.D.

1. Yudkin, John and Roddy, Janet: Levels of dietary sucrose in patients with occlusive atherosclerotic disease. *The Lancet* 2:6 (July 4) 1964.



The Doctor's Library

PSYCHOSOMATIC MEDICINE. Edited by John N. Nodine and John H. Moyer. Pp. 1002. Philadelphia, Lea and Febiger, 1962. \$16.50.

The 120 papers or chapters which make up this large volume are presented as the "First Hahnemann Symposium". Drs. Nodine and Moyer of the Hahnemann Medical College and Hospital selected a group of 135 contributors composed of psychiatrists, neurologists, neurosurgeons, psychologists, neurophysiologists, neurochemists, neuropharmacologists, and internists. This imposing array of well known scientists has succeeded in presenting to the reader a text which integrates the basis sciences of neurochemistry and neurophysiology with clinical correlations. This material plus the lucid way in which it is presented aids then in the diagnosis and management of the psychoneurotic, the psychotic, and the psychosomatic disorders so regularly seen in office or hospital practice of the psychiatrist, internist, or general practitioner.

Although many of the contributors are chiefly in the field of research, the book is clinical in nature so that therapy occupies a major role in each paper. Considerable effort is made to emphasize common psychosomatic conditions such as gastrointestinal reactions, hypertension, headaches of all varieties, neurodermatitis, genitourinary reactions, asthma, back syndromes, etc. Psychodynamics of regularly encountered psychoneurotic reactions such as anxiety and phobic states, conversion reactions, obsessive compulsive states, depressive reactions, are well presented as is the specific approach in the management (office practice) of patients with these involvements as well as patients addicted to alcohol or to narcotics.

The Section on cerebral chemistry and physiology is expertly written for it reads well and is easily assimilated. A large part of the volume is assigned to psychopharmacology to include methods and mechanisms and the objective techniques for evaluating drug responses in man. The Sections on pharmacodynamics and clinical use of tranquilizers, stimulants, and depressants help the reader to clarify the confusion caused by many conflicting claims of the drug manufacturers. Didactic sections on psychoanalysis, psychotherapy, with or without drugs, management of specific psychosomatic conditions seen in outpatients, and finally, implications and projections into the future round out this carefully integrated presentation.

This book will hold appeal for anyone who encounters in his daily routine psychosomatic disorders. He will have an authoritative volume which will prove as a guide as well as a source of treatment. This is one of the finest books to date on psychosomatic medicine and should become a standard textbook.

Louis D. Boshes, M.D.

PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE. George L. Engel. Pp. 435. Philadelphia, W. B. Saunders Company, \$7.50.

The author, himself, in the introduction to this book, states that the content was born of the result of some fifteen years in the teaching of psychological concepts to medical students and to house staff at the University of Rochester School of Medicine and Dentistry. It was hoped that the text would serve as a basic source of data from the sophomore year through resident training in psychiatry and even projected into the field of practice of general medicine. Dr. Engel goes to unusual length to describe the use of his book in a carefully planned lengthy introduction which blends easily into the body of the book proper.

There are two major parts to the work, namely, "Psychological Development" and "Health and Disease." In the former, the author leads the reader in psychosexual development from the stage of dependency through adulthood with both the normal and abnormal carefully described. Unified concepts of health and disease stressing etiology, phenomenology, the role of stress and adaptation with somatic consequences provide a basic introduction to the student who may one day become a psychiatrist.

Although "Psychological Development in Health and Disease" is meant for the student, intern, and resident, it will provide a splendid supplementary source of basic information for the professional psychiatrist or to the general internist who encounters so many patients with psychosomatic disorders in his daily routine.

Louis D. Boshes, M.D.

TEXTBOOK OF SURGERY. Edited by Warren H. Cole and Robert M. Zollinger. Ed. 8. Pp. 1263. New York, Appleton-Century-Crofts, 1963. \$18.95.

This is the eighth edition of a well-established textbook of surgery. Each chapter was revised to include

(Continued on next page)

BOOK REVIEWS (continued)

current concepts and references. Several chapters were rewritten completely including those on nutrition in surgery, pre- and post-operative care, intestinal obstruction, cancer etiology, gynecology, nervous system and several others. The authors also added a new chapter on the subject of pediatric surgery, a rapidly expanding specialty.

The final chapter is of unusual interest because it deals with medical ethics and conduct. Unethical practices such as fee-splitting, ghost surgery, and unjustified operations are strongly condemned. Fifty-nine contributing authors and consultants have cooperated in making this edition one of the best.

T. R. Van Dellen, M.D.

THE ATRIOVENTRICULAR NODE AND SELECTED CARDIAC ARRHYTHMIAS, David Scherf, M.D. and Jules Cohen, M.D.

An understanding of the atrioventricular node and its role in various cardiac arrhythmias is a key to the understanding of much of the complex field of regular and irregular unusual heart action. The authors are extremely well qualified by many years of fruitful investigation to discuss this topic. In general, they have provided a most stimulating and useful volume.

The work commences with a description of anatomical and histological features and goes on to a presentation of physiological aspects. Various specific abnormalities of rhythm are then discussed ending with a lengthy presentation of the pre-excitation syndrome. There is much here to stimulate the cardiologist and the physiologist and indeed there is much material to intrigue and satisfy anyone interested in internal medicine. It would not appear that the material is particularly useful for one engaged in a more general practice.

The style is sometimes clumsy but is generally clear and understandable. At times, the authors list the conflicting views of various workers without attempting to assess the validity of the various points of view. There is a most interesting presentation of the differing views regarding the physiological role of the atrioventricular node and there is a good description of the problem of coronary sinus rhythm and of the role of retrograde and descending block. The complex P wave variations in congenital heart disease are also well discussed and this should be particularly useful to those interested in the field of pediatrics. The authors reject the concept of "coronary nodal rhythm" and believe this is actually a sinus rhythm with a short P-R interval. They discuss the complicated problem of the possible role of functional longitudinal dissociation of the A-V nodal tissue in the re-entry phenomenon without reaching a final conclusion regarding its importance.

There is an excellent bibliography which in itself is of great value. The book is to be thoroughly recommended for those particularly concerned with the field of electrocardiography but is also of decided usefulness to cardiologist, physiologist, and internist.

Oglesby Paul, M.D.

CLINICAL PATHOLOGY: APPLICATION AND INTERPRETATION, Third Edition, Benjamin B. Wells, M.D., Ph.D.

This book in its new edition again fulfills the necessity for an orientation and guide for the practitioner and medical student to the clinical laboratory. The material has been brought up to date. The organization by systems makes it easy to use this as a reference in guiding the physician toward the laboratory tests useful in substantiating a clinical diagnosis. The study guide to methods offers an excellent reference for the doctor who operates an office laboratory or the medical student who wishes to take the extra step himself to make a clinical diagnosis. Additional material might have been presented in a tabular form such as that in the section on coma. The need for such a volume is self-evident to those who practice clinical pathology.

In the section dealing with obstetrics it is recommended that all pregnant patients, regardless of blood type, should be screened for antibodies in their serum. This is easily done with available commercial preparations which employ saline, albumin, Coomb's and enzyme treated cells. The antibodies may occur in any one of these four groups exclusive of the others. This is only a minor deficiency in an otherwise excellent text.

M. C. Wheelock, M.D.

AN ATLAS OF ULTRASTRUCTURE, Johannes A. G. Rhodin, M.D., Saunders Company, Philadelphia, 1963.

Dr. Rhodin has obviously spent a considerable amount of time and effort in the preparation of this book. It is filled with electron photomicrographs of superb quality which illustrate fundamental histological relationships in the various organs of the body. A short text accompanies each illustration.

The Atlas is intended as a supplementary text to the usual histology textbook, and attempts to clear up some of the finer points of structure. No light photomicrographs or line drawings are included—nor are they needed—since the electron microscopic pictures are easily interpreted.

This book will ordinarily serve as a useful library reference text for the interested student of histology. However, its use in the experimental laboratory by research workers or by anyone familiar with electron microscopic illustrations will be limited. For these individuals, the test is less adequate and complete; and the illustrations, although of excellent quality, are not plentiful enough to show the finest points of structure.

M. C. Wheelock, M.D.

HOW TO LIVE TO BE 100, ACTIVELY, HEALTHILY, VIGOROUSLY. By Clement G. Martin, M.D. New York, Frederick Fell, Inc., 1963. Pp. 202. Illustrated. \$4.95.

Man's quest for eternal youth is equalled only by his quest for eternal life. While Martin's book supplies no important new discoveries in the mysteries involved in longevity, it does show the layman how to apply knowledge already available. For those who would outwit Father Time, Doctor Martin suggests a regimen to follow based on three major techniques: (1) exercise, (2) diet, and (3) periodic health examinations. With the

present emphasis on physical fitness it is not surprising that 80,000 copies of this book were sold within nine months of its publication.

The exercises are simple, mostly of the isometric type so popular today, hence they require little time or effort to perform. They are clearly described and accompanied by illustrations easy to follow. They are an expansion of exercises which appeared originally in a pamphlet entitled "Fitness After Forty", published and distributed by the Illinois State Medical Society in 1962. They will appear again in modified form in another pamphlet, "Fully Fit", to be distributed free through drug stores and doctors' offices during Community Health Week in October 1964. Still another version will be issued as a 32-page paperback by the Executive Research Institute for \$1.00.

The common-sense diets, originally presented by the American Medical Association in August 1962, supply a moderate intake of protein, are low in animal fat and contain a moderate amount of polyunsaturated fat.

The periodic examination, Dr. Martin believes, will uncover signs of disease sufficiently early in its natural course so that effective management can be undertaken and thus help to prolong life.

William H. Wehrmacher, M.D.

THE PROSPECT OF IMMORTALITY. Robert C. W. Ettinger. Pp. 190. New York, Doubleday & Company, Inc. 1964. \$3.95.

The author proposes a change in our methods of disposing of the dead in order to ensure immortality. He suggests freezing and storage at a low temperature. Glyccrol will be used to protect the frozen cells.

Mr. Ettinger admits that the best technique of suspended death has not been developed, but is bound to come with research. He believes that most of us now living have a chance for personal, physical immortality. If civilization endures, medical science should eventually be able to repair almost any part of the human body, including damage from freezing, senile debility, or other causes of death. This obviously cannot be done on the deceased who are cremated or are buried in the usual way.

Mr. Ettinger's book is stimulating and provocative. He follows up his unique idea with several chapters on the consequences should the plan be adopted. These include ways in which the super scientist of the future will repair and rejuvenate the individual in frozen sleep. What are the religious and legal aspects? Identity in 2000 A.D. may also be different along with the space required to keep billions of us frozen.

T. R. Van Dellen, M.D.

HANDBOOK OF OCULAR THERAPEUTICS AND PHARMACOLOGY. Philip P. Ellis, M.D. and Donn L. Smith,

Ph. D., M.D. \$8.50, Pp. 193, St. Louis, C. V. Mosby Co., 1963.

A great deal of data on drugs useful in ophthalmology has been compressed by the authors into this slim handbook. This has been done by presupposing that the reader has a basic background in pharmacology and that he is interested in specific answers to therapeutic problems, not in elaborate discussions on the pros and cons of various medications. For example, the chapter on principles of antibiotic therapy consists of eight pages of which three are concise tables of dosages and side effects.

The first half of the book is organized by pathologic entities. For each disease the appropriate drug or drugs are discussed. The second half is a dictionary of pharmacologic agents and much of the material of part I is repeated from this different viewpoint. The material given is timely and current. For example the probable cataractogenic action of triparanol is mentioned as is IDU for superficial corneal herpes.

This is an excellent manual for quick review and is strongly recommended to ophthalmologists and residents in ophthalmology.

David Shoch, M.D.

OCULAR AND ADNEXAL TUMORS: NEW AND CONTROVERSIAL ASPECTS. Edited by Milton Boniuk. Pp. 511, St. Louis, C. V. Mosby Co., 1964. \$25.

This book is a transcription of a symposium held in Houston in November 1962 at the dedication of the new research facilities of the Institute of Ophthalmology of the Texas Medical Center. In keeping with the spirit of the occasion only newer aspects of tumors of the eye and adnexa were considered. This book, therefore, does not replace the older, standard texts in the field but is a valuable adjunct to them.

Formal papers were presented by the outstanding ophthalmic oncologists of this country and Europe in four sessions and each session forms one section of this book. Section I is devoted to tumors of the conjunctiva and eyelid, section II discusses retinoblastoma, section III is on pigmented intraocular tumors and section IV on orbital tumors. These papers were followed by discussions which are here reprinted in full and are perhaps the most valuable portion of the book. The reason for the subtitle "controversial aspects" becomes apparent in these discussions. There are differences in data as well as differences in opinion in most of the discussions which illustrate the ever-changing concepts in the general field of neoplasms, ocular and otherwise.

All in all there is a great deal of thought-provoking material in this handsomely illustrated and well-printed volume. It is recommended to all ophthalmologists and oncologists.

David Shoch, M.D.



Rx Reviews

and New Products

4-in-1 Immunization

A "4 in 1" biological package which provides simultaneous active immunization against poliomyelitis, diphtheria, pertussis, and tetanus in a single 1-cc. injection is being introduced by Eli Lilly and Company.

The new immunizing agent is Tetra-Solgen® (diphtheria and tetanus toxoids and pertussis vaccine, alum precipitated, and poliomyelitis vaccine, Lilly).

Tetra-Solgen offers a simple solution to the problem of maintaining the stability of the pertussis component in a quadruple-antigen preparation. The D-P-T component and the poliomyelitis vaccine are not mixed until the physician is ready to use them.

A concentrated form of Tri-Solgen® (diphtheria and tetanus toxoids and pertussis vaccine combined, alum precipitated, Lilly) in a 1-cc. vial is added to a 9-cc. bottle of poliomyelitis vaccine. The resulting ten-dose mixture will retain full potency for at least one month.

The advantages of Tri-Solgen are retained in the combination package. Tri-Solgen contains an "extracted" pertussis antigen from which the cellular debris of the pertussis organisms has been eliminated. Consequently, there is a much lower incidence of systemic reactions than is observed with D-P-T preparations containing whole-cell pertussis antigen.

Tetra-Solgen is recommended for primary and booster immunization of infants and children against whooping cough, diphtheria, tetanus, and poliomyelitis. Primary immunization may be started as early as one and one-half to two months of age.

Local and systemic reactions are mild and infrequent. There may be some redness, induration, and tenderness at the injection site, lasting twenty-four to thirty-six hours.

Following the injection of any alum or aluminum-containing antigen, a small nodule may develop at the site of injection and remain

for a few weeks before being completely absorbed.

Tetra-Solgen should not be given during an acute illness or feverish condition, or during recovery from surgery, injury, or similar conditions which would depress the response of the immune mechanism.

It is best to postpone to the second year of life primary immunization in infants with a history of central-nervous-system drainage or convulsions. Then the use of single, rather than combined, antigens is preferred.

Initial doses of quadruple vaccine are contraindicated in an outbreak of poliomyelitis because of a potential for "provoking" paralysis in the vaccinated extremity.

Because older individuals are more frequently sensitive to the proteins of the diphtheria and pertussis organisms, a quadruple vaccine is not recommended for immunization after six years of age.

The vial of concentrated Tri-Solgen must be mixed with the vial of poliomyelitis vaccine before use. Administration of 0.5 ml. of undiluted Tri-Solgen concentrate could cause serious general and local reactions.

Antiviral, Antibacterial Agents

One new antiviral agent and three new antibiotics, and the laboratory studies related to them, were recently reported by the Upjohn Company, Kalamazoo, Mich.

The antiviral agent U-13714 and the antibiotics U-11092, U-15774, and U-22956, have been under study at the research laboratories at Kalamazoo. Scientists told of their work on the new compounds at the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, sponsored by the American Society for Microbiology.

The antiviral agent U-13714 is produced by *Streptomyces canarius* var. *canarius*, an ac-

(Continued on page 300)



**PAIN RELIEF
YOU CAN RELY ON**
*comes in minutes...
lasts for hours*

PERCODAN[®]

***in moderate to
moderately severe pain...***

Each scored yellow PERCODAN* Tablet contains 4.50 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

Throughout the wide middle range of pain PERCODAN assures speed, duration, and depth of analgesia by the oral route plus the reliability that counts so much. PERCODAN acts within 5 to 15 minutes...usually provides uninterrupted relief for 6 hours or longer with just 1 tablet...rarely causes constipation.

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of PERCODAN are somewhat less than those

of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also Available:** PERCODAN[®]-DEMI, each scored pink tablet containing 2.25 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. *U. S. Pats. 2,628,185 and 2,907,763
Literature on request.
ENDO LABORATORIES INC., Garden City, New York

Endo[®]

Rx Reviews (cont'd from page 298)

tinomycete isolated from soil. Having the empirical formula $C_{13}H_{21}N_7O_8$, it is active in tissue culture against both DNA and RNA viruses, including vaccinia, Newcastle Disease virus, influenza A, Coe (Coxsackie A-21), and herpes simplex. It is also active *in vitro* against some bacteria. However, U-13714 is significantly toxic to animals.

Its discovery and biological properties were described by Drs. J. J. Vavra and Alma Dietz; its isolation and characterization by Drs. M. E. Bergy and R. R. Herr.

Antibiotic U-11092, produced by *Streptomyces achromogenes* var. *rubradiris* var. *nova*, is active *in vitro* against mainly gram-positive organisms, including two clinical strains of *Staphylococcus aureus*, resistant to several antibiotics.

Fermentation and biological properties were described by Drs. B. K. Bhuyan, S. P. Owen, and A. Dietz; isolation and characterization by Dr. C. E. Meyer.

Another new antibiotic described today is U-22956, produced by *Streptovercillium feruens* var. *melrosporus*. It is active *in vitro* against both gram-positive and gram-negative bacteria, and tests show no cross-resistance with any of the much used antibiotics. This compound is a chemically related metabolite of the two compounds described below.

Its discovery and biological properties were covered by Drs. D. J. Mason, W. L. Lummis, and Dietz.

Two other antibiotics, one of them new, were also described. The new one is U-15774, inactive but unknown until now. It is produced by *Streptomyces achromogenes*, which also produces enteromycin, reported as early as 1954. A third compound, U-22956, already described, completes a group called by Upjohn chemists chemically related metabolites of *Streptomyces*.

Cough Depressant

Lloyd Brothers, Inc. is pleased to announce the introduction of DUAD 10 MG., a new cough medication for the temporary relief of coughs and minor sore throats. DUAD 10 MG. provides a new, pleasant-tasting and convenient form of liquid cough medication in a chewable

capsule sphere which assures accurate dosage at all times. Each chewable DUAD 10 MG. capsule sphere contains: D-Methorphan Hydrobromide 10 mg., Sodium Citrate 50 mg. and Benzocaine 3 mg.

Unlike codeine and many of the other opium alkaloids used as antitussives, non-narcotic d-methorphan has little or no central depressant activity and does not produce analgesia. It has no addicting effects, even after prolonged use in rather high doses. D-methorphan possesses activity approximately as great as that produced by equal amounts of codeine, while the local anesthetic effect of benzocaine acts to relieve irritation from coughs and minor sore throats, and sodium citrate is added as an expectorant. DUAD 10 MG. acts rapidly, usually within 15 or 20 minutes and lasts for approximately 3 to 4 hours.

Directions: Dissolve slowly in the mouth to release liquid medication. Adults: One or two capsules at first sign of a cough. Repeat with one capsule every 3 or 4 hours. Do not exceed 12 capsules in 24 hours. Children 6 to 12 years of age: One capsule every 4 hours. Do not exceed 6 capsules in 24 hours.

Supplied: Bottles of 100 chewable capsules.

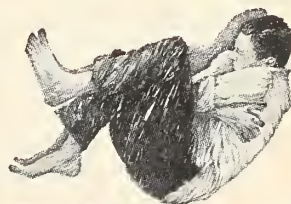
Asthmatic Children Grow Taller, Gain Weight with Anabolic Drug

An anabolic steroid drug enabled a group of growth-stunted asthmatic children to make substantially greater height and weight gains than average children, reports the medical director of the Children's Asthma Research Institute and Hospital in Denver, Col.

Dr. Constantine J. Falliers states in *Pediatrics Digest* (6:49, 1964) that the six-months study revealed weight gains that "exceeded the mean expected semi-annual increments in all patients, ranging from 110 to 330 per cent of the norm." The subjects were fifteen asthmatic children who had been taking corticosteroids continuously and whose growth and maturation had consequently been held back.

Winstrol (stanozolol) was given to these children in an effort to learn to what degree the

(Continued on page 302)



How NALLINE® helps to keep the lid on drug addiction in California

NALORPHINE HCl
INJECTION U.S.P.

The use of the narcotic antagonist NALLINE® (nalorphine HCl injection U.S.P.), as a test of addiction, has significantly curtailed illicit narcotic traffic in Alameda County, California. In penal terms alone, three years after the institution of the test using NALLINE, prison admissions for addiction has dropped from 13.7% of total admissions to 4.4%.¹

The test was given to persons suspected of addiction and to addicts as a condition of probation or parole.

NALLINE does not cure addiction. It can, however, help addicts psychologically, because they know NALLINE detects relapse and that relapse leads to a return to prison or hospital. Definitive answers to the epidemiology of addiction—in itself a symptom of an underlying disease that may be psychologic, physiologic, or pharmacologic in nature—are, as yet, unknown.^{2,3}

The test should be undertaken only by physicians experienced in dealing with narcotic addicts.

INDICATIONS: To reverse significant respiratory depression due to opiates. Diagnostic—to test for opiate narcotic addiction.

CONTRAINDICATIONS: Do not use in mild or non-opiate respiratory depression.

PRECAUTIONS: Due to risk of violent withdrawal symptoms, use with extreme caution and in small doses in narcotic addicts and in

patients receiving opiate narcotics. Effect gradually lost on successive doses; respiratory depression may result.

SIDE EFFECTS: Untoward reactions include dysphoria, miosis, pseudoptosis, lethargy, drowsiness, sweating, pallor, nausea, psychotomimetic manifestations.

Before prescribing or administering, read product circular with package or available on request.

Note: NALLINE will not precipitate abstinence symptoms in meperidine addicts unless they are taking 1,600 mg. or more daily. The ability of NALLINE to detect addiction to codeine is unknown.

References: 1. Brown, T. T.: The Enigma of Drug Addiction, Springfield, Ill., Charles C Thomas, 1961, pp. 287-334. 2. Chesnick, R. D.: Med. Times 90:247 (March) 1962. 3. Narcotic Addiction Symposium: New York Med. 18:562 (Aug. 20) 1962.

SUPPLIED: Ampuls of 1 and 2 cc. and vials of 10 cc., each cc. containing 5 mg. of nalorphine hydrochloride. **Note:** The Federal Bureau of Narcotics now classifies NALLINE as a Class M narcotic preparation. Thus, the purchase of this preparation no longer requires a Federal Narcotic Order Form.



MERCK SHARP & DOHME | where today's theory is tomorrow's therapy
Division of Merck & Co., Inc., West Point, Pa.

INJECTION
NALLINE® HCl
NALORPHINE HCl INJECTION U.S.P.

Rx Reviews (cont'd)

catabolic effects of the corticosteroids could be reversed. While results were generally observable within one month, Dr. Falliers suggests a minimum observation period of several months.

Referring to the substantial weight gains, he says none of the 15 youngsters became obese.

"The general appearance of the child and the consistent increase in the calf circumference suggested that the weight gains reflected muscular growth.

"The growth in height significantly exceeded that of the preceding one to three semesters.

"In several cases the lineal growth rate was almost twice that of the average child of the same age and sex. This acceleration of linear growth generally exceeded the rate of skeletal maturation during administration of stanozolol.

"In the six months following discontinuation of the drug, advances in bone age continued, while linear growth rates were reduced," Dr. Falliers says.

He cites as an important finding that Winstrol made it possible to reduce by 30% the average corticosteroid dose required to control the asthma.

Winstrol is manufactured by Winthrop Laboratories.

Antidepressant

Aventyl® HCl (nortriptyline hydrochloride, Lilly), a new effective antidepressant agent, has been introduced by Eli Lilly and Company for the treatment of mental depression, anxiety-tension states, and psychosomatic disorders, even including those not necessarily connected with depression. In psychiatry, it is useful as an adjunct to psychotherapy and to electroconvulsive therapy.

The new agent has been studied exhaustively for over three years by 150 investigators.

Aventyl HCl is not a monoamineoxidase inhibitor. Since it is a secondary instead of a tertiary amine, it differs chemically from most other tricyclic antidepressants. Chemically it is designated as 5-(3-methylaminopropylidene)-10, 11-dihydro-5H-dibenzo [a, d] cycloheptene hydrochloride.

Pharmacologic studies suggest that Aventyl

HCl has a combination of stimulant and depressant properties. Appropriate experimental methods, including studies of the drug's effect on behavior patterns in animals, have unmasked and separated these.

At present the wide spectrum of pharmacologic activity of Aventyl HCl cannot be ascribed to any single neurohormonal system. Both peripheral and central anticholinergic activity are implied. Evidence suggesting central depressant activity is seen.

In human pharmacology the unusual but statistically valid conclusion is drawn that Aventyl HCl acts as a sedative in controlling agitation in the agitated depressed patient and as a stimulant in its activation of the retarded depressed individual. The control of agitation and retardation to this degree by the same dose of one medication is considered unique.

The introduction of Aventyl HCl makes possible the treatment of a constellation of symptoms. Psychiatric disorders for which it has been used with satisfactory response in a majority of patients include: common types of depression and schizophrenia, alcoholic intoxication, mental deficiency, senile psychoses associated with senile brain disease and cerebral arteriosclerosis, certain psychoneuroses, psychophysiological gastrointestinal reaction, and symptomatic reactions in childhood (for example, bed-wetting).

The total overall response was satisfactory in 79 percent of 1,783 patients classified according to psychiatric diagnosis.

In schizophrenia and mental retardation, concomitant use of Aventyl HCl and a phenothiazine tranquilizer was more effective than either medication used alone.

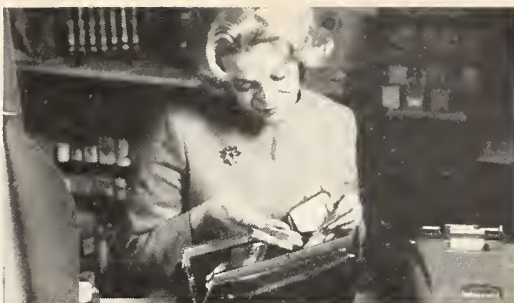
Functional gastro-intestinal disorders have responded to Aventyl HCl most successfully, with 79 percent of 953 such cases showing improvement.

Attenuated Live-Virus Vaccine

With the licensing of its attenuated live-virus measles vaccine, Eli Lilly and Company will have both live and killed-virus measles

(Continued on page 304)

Depend on low-cost,
low-dosage Prolixin
— once-a-day



Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

THE
SQUIBB
TRANQUILIZER

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY
PROLIXIN
SQUIBB FLUPHENAZINE HYDROCHLORIDE

SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB



Squibb Quality—the Priceless Ingredient

© SQUIBB DIVISION **Clin**

Rx Reviews (cont'd)

vaccines for distribution in January, 1965.

The company has had the inactivated-virus vaccine for a year. It will start shipping the new live-virus vaccine to wholesalers January 4, with distribution scheduled for January 25.

Measles Virus Vaccine Live, Attenuated, Lilly, is a suspension of freeze-dried attenuated measles (rubeola) virus of the Edmonston strain. The virus is grown in chick-embryo tissue culture maintained in a synthetic medium. To prevent bacterial contamination, neomycin sulfate equivalent to 50 mcg. per ml. is added during processing.

For convenience in administration and protection of vaccine potency, the new freeze-dried vaccine is supplied with a Hyporet® (disposable syringe, Lilly) containing sterile diluent for reconstitution. Because detergents, preservatives, and antiseptics will inactivate live-virus measles vaccine, *only* the syringe with sterile diluent supplied with the vaccine should be used for reconstitution and administration.

The temperature stability of the vaccine offers new convenience in handling. The product does not require dry-ice containers for distribution since it is stable at 41°F (5°C). It should be kept stored in a refrigerator at or below that temperature. Regular deliveries to retail pharmacists may be made if the temperature of the vaccine is not likely to rise above 70°F.

Measles Virus Vaccine, Live, Attenuated, Lilly, is indicated for immunization of individuals susceptible to rubeola (hard measles, ten-day measles, red measles). It will not protect against rubella (German measles, three-day measles), roseola infantum (exanthem subitum), or other illness which may mimic rubeola.

At least 90 percent of children over nine months of age will be immunized by a single inoculation of live-virus measles vaccine. Immunization should not be attempted in infants under nine months old because of the interference of passive maternal antibody. Older children respond better to the vaccine; hence, the most efficient use is in children over twelve months of age.

Because administration of vaccine made from the attenuated Edmonston strain of measles causes a noncommunicable infection (with fevers over 103°F. occurring in approximately 30 percent of the children), it is recommended that Measles Immune Globulin (Human) be administered concomitantly to minimize the symptoms. Fevers of 103°F. then may be expected in about 15 percent of the children.

Another method that may be employed to decrease the side-effects associated with the live-virus vaccine alone consists in the administration of one, two, or three doses of killed-virus measles vaccine before the live vaccine is given. The live agent may be administered from one month to nine months after the last injection of the killed vaccine. Immune globulin is not used.

If a single dose of killed-virus vaccine is given first, about 3 percent of those receiving live-virus vaccine will have fever higher than 103°F. Two doses of killed-virus vaccine will reduce this incidence to about 1 percent, and three doses to less than 1 percent. Multiple doses of killed-virus vaccine are given about one month apart.

Attenuated live-virus measles vaccine is contraindicated in pregnancy, in cancer patients, and in individuals receiving therapeutic agents which depress resistance, such as steroids.

Because the Lilly vaccine is made in chick-embryo tissue culture, it should be used with caution in persons sensitive to chicken, eggs, or feathers.

The recommended immunizing dose of reconstituted Measles Virus Vaccine, Live, Attenuated, is a single subcutaneous injection of 0.5 ml. It is recommended that it be followed immediately by intramuscular injection (in another extremity) of Measles Immune Globulin (Human) 0.01 ml. per pound of body weight.

In the killed-live vaccine regimens, each dose of Measles Virus Vaccine, Inactivated, Aluminum Phosphate Adsorbed, Lilly, is 1 ml., given intramuscularly.

Measles Virus Vaccine, Live, Attenuated, Lilly, is supplied in a combination package
(Continued on page 306)

Needs
^

FOR THE PATIENT WHO REALLY WANTS TO LOSE WEIGHT...

Your Supervision

Obedrin-LA

Obedrin Menu Plan



The success of practically any weight control plan depends on the patient's attitude. An understanding of the underlying causes of food craving and a strong willingness to solve the problem of overweight are necessary. Lack of this attitude explains the infrequent success of many ventures in weight control.

For your patient who really needs to lose weight, this program is most effective:

***PHYSICIAN SUPERVISION**—to plan a safe, effective and individually tailored route for weight loss, with frequent physical checkups to uncover any elements which may change the plan.

***OBEDRIN-LA**—not just an anorectic, Obedrin-LA covers a wide range of needs from vitamin supplementation and tissue fluid mobilization to appetite suppression and mood elevation in one convenient,

all-day, optimum level, "trickle release" form.

***OBEDRIN MENU PLAN**—a common sense diet that solves the problem of calorie-counting while encouraging sustained good eating habits after weight reduction is accomplished.

Dosage is 1 tablet daily, usually at 10 a.m.

Supplied in bottles of 50 and 250 tablets, on prescription only.

Caution: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage. Use with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

Long-Acting Obedrin[®]-LA^{*} "TRICKLE RELEASE" TABLETS

Each tablet contains: Methamphetamine HCl*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Nicotinic Acid (Niacin), 10 mg.

*U.S. Pat. Nos. 2,736,682; 2,809,916; 2,809,917; 2,809,918 and pat. pend.

THE S. E. MASSENGILL COMPANY Bristol, Tennessee • New York • Kansas City • Chicago • Dallas • San Francisco

Rx Reviews (cont'd)

containing one 0.5-cc. -size vial (V1271) of the virus vaccine and one Hyporet in which there is sterile diluent for reconstitution and administration of the vaccine.

Measles Immune Globulin (Human) is supplied in a 2-cc. vial (V1272).

New Oral Contraceptive

Provest, the newest oral contraceptive, apparently is safe and well-tolerated, according to a report on a test series in which 106 patients received the drug for over 1100 cycles with no unwanted pregnancies.

Women who stopped taking the drug because they desired early conception became pregnant almost immediately; pregnancy was delayed in only one instance.

Dr. Eduard Eichner of Mount Sinai Hospital, Cleveland, who conducted the clinical trial, also reported that there were no abnormal infants and that toxic or undesirable effects were minimal.

Provest, developed by research scientists of The Upjohn Company, is a combination of its progestational agent, Provera, and ethinyl estradiol in a ratio of 200 to 1. A 20-tablet "Daypak" of the drug is intended for use on a tablet-a-day schedule from the 5th through the 24th day of the menstrual cycle.

As of last January, Dr. Eichner said that seventeen women had been in his study for over 18 months and three for over 31 months. Seventy-three had dropped out, including 26 who withdrew for personal reasons, 12 who wished to become pregnant, and 8 who were undergoing surgery.

Of the remaining withdrawals, 19 were blamed on irregular or prolonged bleeding and 8 on bloating and breast congestion. "It is noteworthy that less than 10% complained of bloating and breast congestion, and that many of those who stopped treatment because of bleeding did so in the very early phases when there was a lack of knowledge of the optimum dose," Dr. Eichner stated.

Smallpox Vaccine Innovations

Dried smallpox vaccine and the use of a

bifurcated needle have paved the way for improvements in vaccination procedure. Wyeth Laboratories, Philadelphia pharmaceutical manufacturer, has outlined these innovations in announcing the availability of a new type package of DRYVAX® smallpox vaccine.

This potent, dried vaccine, recently patented by the Company, comes in a vial sealed in a vacuum. In this form, the vaccine can be stored unrefrigerated for up to 18 months without loss of potency. A solution for "reconstituting" the dried vaccine is included in a separate cartridge that is capped with a hollow needle. Final item in the hinged, polyfoam package is a dispenser with 100 sterile, two-pronged, disposable needles.

Pain Relief After Oral Surgery

By allaying anxiety and tension, the drug Trancogesic substantially raised the pain threshold in patients after dental surgery requiring sutures, thereby effectively controlling post-operative pain, two dental surgeons report in the *Journal of the Missouri Dental Association* (44:23, 1964).

The drug, manufactured by Winthrop Laboratories, is a combination of Trancopal, a tranquilizer and muscle relaxant, and aspirin. The study of 100 patients of both sexes was carried out at St. Louis University School of Dentistry by Drs. John C. Versnel and George Shevlin. Each patient was given two tablets before surgery and two tablets every four hours after surgery, for a maximum of eight tablets in 24 hours.

Of the 90 patients evaluated (10 were excluded from the results), the investigators report that 70 were completely relieved of pain, usually within 15 minutes. In 68 patients, pain relief lasted four hours.

Eleven patients reported experiencing no pain, of whom six had been given only two tablets of Trancogesic preoperatively, and an additional three patients had taken two tablets preoperatively and two tablets at bedtime. The remaining two patients in the group of 11 had taken all 12 tablets.

(Continued on page 308)

Fewer bacterial resistance problems when you treat infections



PENBRITIN[®]

Brand of Ampicillin

kills bacteria...does not just suppress them!

With PENBRITIN (ampicillin) the emergence of resistant strains of organisms is *slow* rather than rapid as with other antibiotics.^{1,2} Tetracycline-resistant hemolytic streptococci and pneumococci have been reported^{3,6}—but this has not been a problem with PENBRITIN (ampicillin). According to an editorial in *Lancet*,² PENBRITIN (ampicillin) could be particularly valuable in *killing* coliforms and *Proteus*, which may otherwise quickly become resistant during treatment. Recently, several *Shigella* strains, resistant to tetracycline, chloramphenicol, and other antibiotics, were found to be susceptible to ampicillin.⁷

Dosage: Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Rolinson, G. N., and Stevens, S.: *Brit. M. J.* ii:191 (July 22) 1961. 2. Editorial. *Lancet* ii:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.*: *Brit. M. J.* i:1550, 1962. 4. Evans, W., and Hansman, D.: *Lancet* i:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Rycroft, J. A.: *Lancet* i:553 (March 9) 1963. 6. Schaedler, R. W., *et al.*: *New England J. Med.* 270:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

AYERST LABORATORIES, NEW YORK, N.Y.

Distributors for
BEECHAM RESEARCH LABORATORIES INC.

Rx Reviews (Cont'd)

New Products Forthcoming

Anticipated introduction this year of two important diagnostic agents is reported by the newly-created Pfizer Diagnostics Department, Chas. Pfizer & Co., Inc.

The announcement highlights the group's first national sales and training meeting which is convening here this week.

Some 39 regional supervisors, diagnostic sales representatives and technical service representatives heard promising news about the projected 1965 introduction of Seroscreen and Phenascree by Pfizer Diagnostics.

Seroscreen is a simple and rapid screening test for syphilis. Phenascree is a fast method for detecting elevated levels of serum phenylalanine in newborn infants. Elevated serum phenylalanine levels are known to be associated with phenylketonuria, a cause of mental retardation.

The newly-organized and specialized Pfizer Diagnostics field force also is reviewing the existing product line. In addition, a major portion of the meeting is devoted to laboratory demonstrations and practical exercises with Jack Cassorla, technical service coordinator, and Julia M. Mann, manager of professional services, conducting these workshops.

Pfizer Diagnostics produces many diagnostic aids, blood testing and coagulation reagents. The Department also specializes in scientific services for physicians, medical technologists and clinical laboratories. Its technical service representatives conduct approximately 150 diagnostic workshops a year for medical technologists throughout the country.

The Pfizer Diagnostics Department is a unit of Pfizer Laboratories, a pharmaceutical marketing division of Pfizer. Pfizer Diagnostics was organized January 1 with Knickerbocker Biologics forming the nucleus of the department. Knickerbocker was started in 1949 and acquired by Pfizer in November 1962.

The sales team was informed by Joseph L. de Cillis, director of operations, that Pfizer Diagnostics was organized to enlarge and centralize Pfizer's role in diagnostic research, production and sales. Julian Claitman, director of marketing, outlined how the field force would

provide nation-wide coverage. Pfizer Diagnostics has been divided into Northeast, Central, Southern and Western Sales Regions with a regional supervisor in charge of a team of diagnostic sales representatives and technical service representatives.

Antifungal Agent

The first specific medication for the treatment of the superficial fungous infection, tinea versicolor, has been introduced by the Schering Laboratories Division of Schering Corporation.

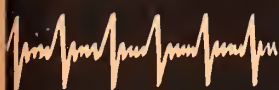
Known as Akrinol (acrisorcin), the compound has been found to have antifungal activity against *Malassezia furfur*, the causative organism for tinea versicolor. The drug has been studied by several hundred dermatologists during the last few years.

The new agent produced "good to excellent results" in 39 of 40 patients observed by Dr. Erwin H. Zimmerman of Huntington, N. Y., whose report appeared in the *Journal of the American Medical Association* in April, 1961. "It far surpasses any medication that I have previously used for this infection (tinea versicolor)," he stated. Of the 40 patients, 34 showed excellent results and five of the remaining six had "a good response".

According to Dr. Zimmerman, Akrinol is a "rapidly effective, easily applied, pleasant and safe therapeutic agent." The contrasts with previously available medications which Dr. Zimmerman reports as having been "only partially effective and which required daily baths, followed by applications of malodorous preparations for prolonged periods of time."

The lesions of tinea versicolor vary from golden yellow to dark brown and tend to erupt on surfaces of the body ordinarily covered by clothing. Mild itching and unsightliness are the main problems of this disease. Akrinol Cream causes all evidence of tinea versicolor to disappear in a matter of days in most cases. However, treatment should be continued twice daily for at least six weeks to ensure complete eradication.

Free of odor and pharmaceutically acceptable, Akrinol has an exceptionally low incidence of local irritation. Produced in 50-gram tubes, it will be available only upon prescription.



PULSE

of the ILLINOIS STATE MEDICAL SOCIETY



A Service of the Public Relations Division

March, 1965

Medical Journalism Awards Go to TV, Radio, Press for Contribution to Public Understanding

A total of eight newspapers, four radio stations and a television station recently were singled out for special honors by the Illinois State Medical Society for their "outstanding contributions to a better public understanding of medicine and health in Illinois."

The occasion was the ISMS Annual Medical Journalism Awards Dinner at the Ambassador East Hotel, Chicago. Representatives of mass media from throughout the state were on hand for the awards ceremony conducted by Dr. Leo P. A. Sweeney, chairman of the ISMS Committee on Public Relations. The presentations were made by Dr. Edward A. Piszczek, society president.

The "Outstanding News Story" award for a metropolitan daily newspaper went to the Chicago Tribune for science writer Roy Gibbons' article "Breakthrough Near: Oral or Spray Lifetime Mumps Vaccine."

Cited among metropolitan daily newspapers as the "Outstanding Medical Series" was Chicago's American for special sections editor Don DeMichaels' series "How I Beat My Heart Attack."

Winner among metropolitan dailies of the "Outstanding Medical Feature" award was the Chicago Daily News for science editor Arthur Snider's "Cancer Report: Growing Hope, Many Mistakes."

Winners in the downstate daily newspaper category included:

Illinois State Register, the "Outstanding Medical News Coverage" award for writer George Derwig's reporting on the encephalitis outbreak.

Rockford Register-Republic, the "Outstanding Medical Feature" award for writer Phil McCombs'



A switch in their usual communications role, these broadcasters found themselves "in" the news when their stations were cited by ISMS for their contribution to public understanding of medicine and health in Illinois. Included, from left, are (seated) Edward Wallis, general manager, WIND; Bruce Dennis, news manager, WGN-TV; Howard Keegan, program coordinator, WMAQ; (standing) Phil Lind of the "Weekend With Phil Lind" show, WAAF; and Reese Rickards, public affairs director, WJJD.

"Dead Man's Eyes Give Local Woman Sight."

Rockford Register-Republic, the "Outstanding Medical Series" award for writer Doug Adams' report on "Child Beating."

Winners among weekly newspapers throughout the state included:

McLeansboro Times Leader, the "Outstanding Continuing News Coverage" award, for editor Ed Kirkpatrick's reporting on the encephalitis outbreak.

Highland Park News, the "Outstanding Medical Feature" award for writer Marvyn Wittelle's

"New Knowledge, Renewed Confidence for Nurses."

The Bulletin (Chicago), the "Outstanding Medical News Story" award for writer Alex Zelchenko's "Urge Parents to Cooperate With TB Testing at Parker."

Singled out for distinction among Illinois television stations was WGN-TV for its one-hour color documentary on Cook County Hospital entitled "Halls of Mercy."

Radio station winners included:

(Continued on Page 2)

McDonough Physicians Conduct Immunization Program for Thousands

The McDonough County Medical Society reports that its adult immunization program—conducted with the cooperation of a number of local service clubs—resulted in a total of 3,000 diphtheria-tetanus shots and 1,900 smallpox vaccinations administered to citizens of the community.

Said Dr. D. H. Dexter, McDonough society public relations chairman:

"Our 17-man medical society donated approximately 72 hours of actual work to the program—in addition to committee meetings—and at no time was serious complaint heard from the doctors. Rather, they all seemed to thoroughly enjoy this privately financed, privately operated community service of medicine."

Eye-Catching Billboards Urge Citizens 'Save Your Vision With Examinations'



This eye-catching poster—appearing during March on more than 150 billboards throughout Illinois—hopefully is also capturing sufficient interest and concern to motivate citizens to do something about protecting their sight. That "something," of course, is an eye examination. This month's "Save Your Vision" preventive medicine campaign is being conducted by ISMS with the cooperation of the Illinois Society for the Prevention of Blindness.

8 Papers Win Laurels for Medical Coverage

(Continued from Page 1)

WMAQ, the "Best Dramatization" award for its two-part series on alcoholism entitled "Financial-Six-One-Four-Seven-Five."

WIND, the "Best Documentary" award for its "Challenge" program dealing with psychiatry.

WAAF, the "Best Interview Show" award for its "Weekend With Phil Lind" show dealing

with medical progress in the treatment of arteriosclerosis.

WJJD, the "Outstanding Community Service Project" award for its campaign of spot announcements promoting citizen participation in a glaucoma program.

Judges for the television entries were Bill Irvin, TV columnist for Chicago's American, and James Green, midwest regional manager

of TV Guide.

Judges for the radio and newspaper entries—provided under the auspices of the Publicity Club of Chicago—included: Merrill R. Swartz of Griswold-Eshleman Co.; Ralph Liguori of Curtis Circulation Co.; Mrs. Dene R. Murray of the National 4H Service Committee; and Brace Pattou of Charles Feldstein Co.



Looking into the camera for a change are these representatives of Illinois newspapers singled out for distinction in the ISMS Annual Medical Journalism Awards Program. They are, from left, Ed Kirkpatrick, editor, McLeansboro Times Leader; Arthur

Snider, science editor, Chicago Daily News; Doug Adams, reporter, Rockford Register-Republic; Jack Scholler, city editor, Rockford Register-Republic; Don DeMichaels, special sections editor, Chicago's American; K. Steve Anderson, assistant director of

publications for North Shore Group Newspapers, Highland Park News; Mrs. Ann Tyson, an editor for The Bulletin of Chicago; George Derwig, reporter, Illinois State Register, Springfield; and Ron Kotulak, reporter, Chicago Tribune.

ISMS Urged to 'Tell Eldercare to the People'

More than 150 physicians from throughout Illinois paid a "house (and senate) call" on the 74th General Assembly for the Illinois State Medical Society's Annual Legislative-Public Affairs Conference, Feb. 23, in the Hotel St. Nicholas, Springfield.

Highlight of the day was an address by Dr. Donovan F. Ward of Dubuque, Iowa, president of the American Medical Association.

Dr. Ward urged the Illinois physicians to "tell the people the medical profession's side of the story" in the Congressional contest between its Eldercare proposal and the administration's Medicare plan.

"We have no time to lose," he said. "Tell the people that Eldercare would provide a much wider spectrum of benefits—including physicians' care, surgical and drug costs, hospital and nursing home charges, diagnostic services, x-rays and laboratory fees and other services for people over 65 who cannot afford them."

Dr. Ward termed use of the word "Medicare" a "lie and deception" because the plan only provides for limited hospital and nursing home charges.

The AMA chief reported that a recent Congressional poll showed that there were only 160 to 165 "sure votes" for Medicare.

"We can win," declared Dr. Ward. "We have the will to win, and we will win!"

Presiding at the legislative conference, under the chairmanship of Dr. J. Ernest Breed of Wilmette, was Dr. Burtis E. Montgomery of Harrisburg, president-elect of the state medical society.

The conference concluded with a reception and dinner in honor of Governor Otto Kerner and some 300 representatives, senators and their wives.

Crawford MD's Hear Welch

At the regular meeting of the Crawford County Medical Society, Dr. N. M. Welch of Vincennes, Indiana, gave a paper on "Prostatic Disease." Dr. Welch, a urologist, is a member of the Crawford Memorial Hospital consulting staff in Robinson.



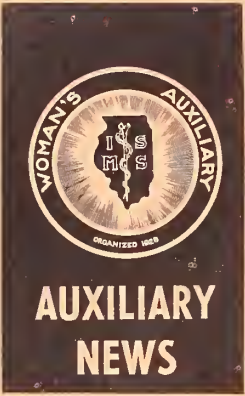
SPRINGFIELD—Wilmette physician Dr. J. Ernest Breed, left, confers with American Medical Association President Dr. Donovan F. Ward, right, of Dubuque, Iowa, at the Illinois State Medical Society's Legislative-Public Affairs Conference in the Hotel St. Nicholas here. Standing is Dr. V. P. Siegel of East St. Louis, chairman of the ISMS Legislative Committee. Dr. Breed, member of the society's board of trustees, was conference chairman.

Dirksen Vows Opposition to Health Financing Through Social Security



WASHINGTON, D.C.—Senator Everett Dirksen smiles in agreement with leaders of the 50-member ISMS delegation seeking to enlist his support of the medical profession's approach to broader health care benefits for the elderly. Dirksen vowed his opposition to the administration's Medicare proposal to finance health costs through the Social Security system. The physicians, from left, are Dr. John Newkirk of Elgin, chairman of the ISMS Committee on Public Affairs; Dr. V. P. Siegel of East St. Louis, chairman of the ISMS Committee on Legislation; Dr. Jacob E. Reisch of Springfield, ISMS secretary-treasurer; Dr. William E. Adams of Chicago, chairman of the ISMS board of trustees; and Dr. Edward A. Piszczek of Chicago, ISMS president.

Dr. Nyaradi, Luncheon and Fashions, 'Night on the Town' Spark Convention



EDITOR

Mrs. Oliver
Veneklasen

ASS'T EDITOR

Mrs. Theadore
Proud

A stellar program has been announced by Mrs. M. Spellberg, chairman, for the Thirty Seventh Annual Convention of the Woman's Auxiliary to the Illinois State Medical Society, May 16-19, 1965, in Chicago's Sherman House.

Activities during this 37th annual meeting of physicians' wives will include workshops, the election and installation of officers, addresses by prominent speakers, election of delegates to the national convention and presentation of awards and certificates to counties.

Focal points of the woman's assembly include:

"Open House" in the President's Suite, on Monday, May 17, where each member will have an opportunity to personally meet the president and president-elect.

"Night on the Town" with dinner and show at the "Athens", at 6:30 on Monday, May 17.

"Continental Breakfast" at 8:00 a.m., on Tuesday, May 18, in the George Bernard Shaw Room, with Workshops conducted by state chairman.

"Luncheon" at Jacques French Restaurant, with fashion show at "Blums Vogue" on Tuesday, May 18, honoring the president-elect of the Woman's Auxiliary to the American Medical Association, Mrs. Richard Sutter.

Annual banquet of the Illinois State Medical Society in the Grand Ballroom, Tuesday, May 18, at 7:00 p.m. County Presidents of the Auxiliary will serve as hostesses.

"Stronger Than the Atom," address to be given by Dr. Nicholas Nyaradi, on Wednesday, May 19. Dr. Nyaradi, director of the School of International Studies at Bradley University, was born and educated in Hungary, was a former Minister of Finance in Hungary, and now is an American citizen. Dr. Nyaradi was recently awarded the George Washington Medal of the Freedom Foundation at Valley Forge.

"Installation Luncheon," honoring Mrs. Willard C. Scrivner, outgoing president; Mrs. John Koenig, incoming president; and all past state presidents, in the Bal-



DR. NICHOLAS NYARADI

Tabarin Room, at 1:00 p.m., May 19. During this luncheon, members and guests will be entertained by a group of strolling musicians.

Mrs. Scrivner Will Exchange Gavel for Historic Scrapbook

A scrapbook of press clippings on medical society auxiliary activities throughout the year will be presented to President Mrs. Willard Scrivner when she surrenders the gavel to her successor at the 37th annual women's convention in May.

However, Mrs. Helen Knaus of Belleville—state publicity chairman responsible for compiling the scrapbook—reports that the presentation still lacks newspaper items from a number of counties.

So that each county can be represented in the book, Mrs. Knaus suggests that all publicity chairmen look for the following kinds of auxiliary items in their newspapers:

Member participation in local, national or world affairs; delegates to district, regional or state meetings; elections; tours; awards; new projects; study groups; benefit programs; resolutions on matters of public interest; fashion shows and regular meetings.

Clippings, with identification of newspaper and date of appearance, should be sent to Mrs. William Knaus, 22 County Club Acres, Belleville, Illinois.

Sen. Dirksen to Millie: Millie to Sen. Dirksen: 'Charmed, I'm Sure!'



The Woman's Auxiliary was well represented among the Illinois medical profession's delegation to the ISMS annual public affairs conference in the nation's capitol. Here Senator Everett Dirksen—widely reputed as a "charmer"—is himself charmed by Mrs. Eugene Vickery of Lena, Auxiliary rural health chairman and representative to the ISMS Committee on Legislation. Mrs. Vickery is past president of the Woman's Auxiliary to the Stephenson County Medical Society.

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



1965 ANNUAL MEETING

The Illinois Medical Assistants Association will hold their annual meeting on April 23, 24 and 25 at the Holiday Inn, 401 N. Main Street, East Peoria Illinois. The host chapter will be Peoria Medical Assistants Association. Following is the program for the meeting:

Friday, April 23, 1965

6:00 P.M. Pre-registration.

9:00 P.M. Council Meeting (tentative time)

Saturday, April 24, 1965

8:00 A.M. Registration.

9:00 A.M. House of Delegates and General Assembly
(Corinne Berg, President, presiding.)

12:30 P.M. President's Luncheon
(Anne Newingham, Convention Chairman, presiding)

Invocation: Rev. Merrill Hershberger, Pastor,
Glen Oak Christian Church, Peoria.

Welcome: Stella Wayman, President, Peoria Chapter

Speaker: Dr. Nicholas Nyardi, Director
School of International Studies at Bradley Univ.
Former Minister of Finance of Hungary
Born and educated in Hungary; now an American citizen
Two doctor degrees from the Royal Hungarian
Univ. of Budapest—one in political sciences
and one in jurisprudence. Doctor Nyardi
was an attorney for 13 years and also the
legal advisor and executive director of one
of the largest banks in Hungary.

2:15 P.M. "Rhinoplasty"—plastic surgery of the nose (color sound film)
Doctor Morris H. Cohen, Otolaryngologist

3:15 P.M. "Artificial Kidney Demonstration"
Doctor John W. Otten, Surgeon
Doctor James Myers, Internist
Doctor Edward Schlicksup, Urologist
Miss Virginia Graber, R.N.
Miss Jane Hanley, R.N.

This is the TEAM that
will explain and
demonstrate the use of
the Artificial Kidney

4:30 P.M. Uniform Style Show
Courtesy of: Bussman's Uniform Center, 813 E. War Memorial Drive,
Peoria, Illinois

6:30 P.M. Cocktail Hour

7:00 P.M. Installation Banquet
Corinne Berg, presiding

Invocation: Rev. Father Richard Mullen, Chaplain at
Guardian Angel Orphanage, Peoria

Speaker: "Office Manners and Policies"
Miss Helen Cockrill, Dean of Secretarial School,
Midstate College of Commerce

Installation Ceremony by: Edward A. Piszczik, Pres. Illinois State
Medical Society.

Following Banquet, President's Reception and Hospitality Room in Registration
Suite.

Sunday, April 25, 1965

9:00 A.M. Breakfast.

10:00 A.M. Speaker: Mr. Frank Pierson, R.P.T., Forest Park Foundation,
St. Francis Division, Institute of Physical Medicine
and Rehabilitation, Peoria (topic to be announced)
Council meeting to follow.

WILL YOUR MEDICAL ASSISTANT BE THERE, DOCTOR? She does not need to belong
to the Association to attend. She may come as a guest. Send check or money order
to "I.M.A.A. Convention Fund" and mail to Mrs. Anna Mary Cooper, Convention
Chairman, c/o Doctor C. V. Ward, suite 1001 Lehmann Bldg., Peoria Illinois 61602.

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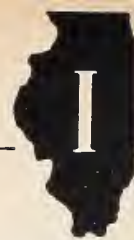
Somewhat amazingly, \$3.18 is correct. Even if you eliminated pharmaceutical manufacturer's net profit, your patient would pay only about 17 cents less for the average prescription—hardly a deciding factor in having it filled. Of course, this assumes that pharmaceuticals could continue to be available without profit (where do new miracle drugs come from, if not profit?).

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This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

*Average prescription price, 1963. National Prescription Audit, R.A. Gosselin, Dedham, Mass.



Appointments

Florence K. Tryhus, RRL (Registered Record Librarian), was formally installed as president of the American Association of Medical Record Librarians at the association annual meeting, Miami Beach, Florida, October 11-15.

Mrs. Tryhus, who is director of the medical record department, Palo Alto-Stanford Hospital Center, Palo Alto, California succeeds M. Loyola Voelker, RRL, director of the School of Medical Record Librarians USPHS Hospital, Baltimore, Maryland, now serving as past president director.

President-elect of the professional association is Mary E. Converse, RRL, director of the central office on International Classification of Diseases, Adapted, Chicago, Illinois.

Over 600 medical record librarians from across the nation attended the 36th annual meeting of the AAMRL. In addition to the business of the association (the only professional organization of its kind) the members heard papers on problems of automation in medical record administration, the place of research in private hospitals, the medical-legal aspects of drugs and records and the hospital's responsibility for paramedical education programs.

Nathan W. Helman, executive vice president of Mount Sinai Hospital, has announced the appointment of Dr. Emanuel Brams, 1250 North Lake Shore Drive, as head of the hospital's Special Diagnostic Laboratories.

Prior to assuming his new duties Dr. Brams was supervisor of Mount Sinai's emergency room and medical coordinator of the hospital's home care program.

A native of Boston, Dr. Brams received his A.B. degree Cum Laude from Harvard and his M.D. from Tufts University. He interned at the University of Illinois Research and Education Hospital and continued his residency training there and at Presbyterian St. Luke's Hospital.

In preparation for his new post Dr. Brams took a special course at the Atomic Energy

Commission's school at Oak Ridge in the use of radioisotopes in medicine.

PG Courses

The Cook County Graduate School of Medicine announces a two-week intensive continuing education course in The Neuromuscular Diseases of Children with Special Emphasis on Management, to be given by Dr. Meyer A. Perlstein for the period of June 7-18, 1965. This is an intensive didactic and clinical course designed for Pediatricians, Orthopedists, Neurologists, Phychiatrists and Psychiatrists interested in the care and treatment of children with neuromuscular handicaps. Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures. The course will include trips to demonstration clinics and treatment centers. The fee for the course is \$290, and since registration will be limited, applications should be made as far in advance as possible. For further information, write to the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago Illinois 60612.

New Literature

In step with the nationwide effort among official and voluntary agencies to support and encourage educational programs against smoking among young people, a teacher resource kit, "Smoking and Health," has been developed in Illinois.

The kit was assembled by the Illinois Department of Public Health and the Office of the Superintendent of Public Instruction.

Resource information is built around a booklet entitled, "Teaching About Smoking and Health," written by three Illinois educators. The first part of the booklet is a condensed compilation of the latest scientific data relating to smoking. The second part is devoted to teaching sug-

gestions on smoking and health. The kit also contains representative resource literature and sample materials.

The kit is available to teachers responsible for teaching about smoking and health. Teachers may obtain kits by contacting the supervisor of health education, Office of the Superintendent of Public Instruction.

According to Ray Page, superintendent, sample kits have been sent to all principals of junior and senior, public and parochial high schools in the state, as well as to departments of education of universities, colleges and junior colleges.

Dr. Franklin D. Yoder, state public health director, said kits have been sent to all regional health offices, local health departments and medical societies in Illinois.

Inquiries concerning the kit may be directed either to the Supervisor of Health Education, Office of the Superintendent of Public Instruction, or Chief of the Bureau of Health Education, Illinois Department of Public Health.

Dr. Staras returned to Galesburg State Research Hospital as staff psychiatrist, and successive promotions to chief of service, assistant clinical director and clinical director. In August

1962 he was appointed to his present position of assistant superintendent of Jacksonville State Hospital.

At Jacksonville Dr. Staras was responsible for coordinating the special training program conducted by a visiting consultant team from the Chicago Psychoanalytic Institute, a part of the continuing Department of Mental Health program for improvement of staff.

A "Manual of Medical Radioisotope Technique" has just been published by Nuclear Consultants Corporation, 9842 Manchester Road, St. Louis, Missouri 63119. The book is 175 pages in length and was edited by Lloyd G. Struttman, Director of the Medical Physics Consulting Staff of the company.

The manual provides unusually complete coverage of its subject, starting with an examination and explanation of the physical principles involved, and the derivation and application of the basic radioisotope units. There are also sections on radiation protection, Atomic Energy Commission Regulation, license application

(Continued on page 326)



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MEDICAL DIRECTOR

Meeting Memos



March 31-April 2

A continuing medical education symposium on Gastroenterology will be presented March 31-April 2, 1965 at the Medical College of Georgia, Augusta, Georgia. The guest faculty includes three nationally recognized teachers and clinicians who will join with members of the Medical College of Georgia faculty in discussing the medical and surgical approach to problems in gastroenterology. Sports-minded physicians are reminded that this symposium immediately precedes the Masters Golf Tournament which will be played at the Augusta National Golf Club, April 4-11. For a symposium brochure listing the subjects to be discussed and participating faculty, write to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

April 2-4—The American Society For The Study of Sterility will hold its 21st Annual Meeting at the Jack Tar Hotel in San Francisco. The registration for nonmembers is \$10.00. Make checks payable to The American Society For The Study of Sterility, 2700 Tents Avenue South, Birmingham, Alabama 35205.

April 3—A one day seminar in diseases of the nervous system clinical and pathological considerations will be held in St. Louis, Missouri, sponsored by the Missouri Society of Pathologists and conducted by John J. Kepes, M.D., Associate Professor of Pathology and Neuropathologist, Kansas University Medical Center and Dewey K. Ziegler, M.D., Professor of Medicine (Neurology), Kansas University Medical Center. For advance registration, including slides and case abstracts, send checks for \$10.00 to: James G. Bridgens, M.D., Secretary, Missouri Society of Pathologists, St. Joseph's Hospital, Linwood at Prospect, Kansas City, Missouri 64108. Abstracts only, without slides—\$2.00.

April 4-8—The American College of Obstetricians and Gynecologists will hold its 13th Annual Clinical Meeting Sunday-Thursday, April 4-8, 1965, at the Civic Auditorium in San Francisco. Sunday will be devoted to registration, with the official opening of the meeting scheduled for Monday morning.

Scientific papers, round tables, panel discussions, luncheon conferences, forums on current investigations, motion pictures, closed-circuit color television programs, and scientific and industrial exhibits will comprise the program. Emphasis will be placed on discussion and audio-visual aids, rather than on formal presentation of papers.

A variety of obstetric-gynecologic topics are scheduled for discussion treatment, including the role of the OBG physician in marriage and family problems, amenorrhea, early fetal loss, cervical cancer, reproductive biology, dysfunctional bleeding, perinatal loss, sociologic and medical aspects of sterilization, toxemia, and bleeding in late pregnancy.

Among the topics of formal papers will be prenatal factors influencing the premature infant, treatment of vulvar malignancies, surgical treatment of cervical cancer, elective induction of labor, fetal salvage in eclampsia, pregnancy and progeny following prolonged use of progestin-like substances for contraception, and the effects of caudal anesthesia on uterine activity.

One of the Correlated Seminars will be devoted to advances in electronic technics and equipment for obstetrics and gynecology. Among the subjects will be thermography, lymphangiography, amniography, mammography, and pelvic pneumography.

Included in the Forums on Current Investigation will be presentations on ultrasonics in obstetrics and gynecology and the use of electron spin resonance (ERS) in normal and malignant tissue. The ERS technique utilizes a conventional spectrometer to compare resonating signals from normal and suspected malignant tissues.

April 18-21—The West Virginia Academy of Ophthalmology and Otolaryngology will hold its eighteenth annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia. An outstanding scientific program is planned which will include Dr. Arthur G. DeVoe, New York, speaking on Complications of Caneal and Cataract Surgery; Dr. Philip M. Lewis, Memphis Tennessee, with two lectures on Complications of Cataract Surgery; Dr. Nathan S. Schlezinger, Philadelphia, Pennsylvania, who will speak on Neuro-ophthalmological Aspects of Myasthenia Gravis and Clinical Significance of Isolated Oculomotor of Abducens Paralysis; Dr. David Austin, Chicago, Illinois, who will speak on Ossicular substitutes and repair and Treatment of Meneire's disease; Dr. Edwin W. Coeke, Memphis, Tennessee, with lectures on Evaluation and Treatment of a Lump in the Neck and The Management of Parotid Gland Tumors; and Dr. David A. Dolowitz, Salt Lake City, Utah, who will speak on Control of Allergy with Heparin. A registration

fee of \$35 for associate members will cover all social and scientific sessions. For additional information, please contact the secretary, Worthy W. McKinney, M.D., Professional Park, Beckley, West Virginia.

May 15—All physicians, registry secretaries, record librarians and administrators are urged to attend a workshop on administrative problems of cancer clinical activities and registries, John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago, Illinois, 9:00 a.m. to 3:45 p.m. Jointly sponsored by the Illinois State Medical Society, the Illinois Division of the American Cancer Society, the Illinois State Department of Health and the American College of Surgeons, this workshop will present statewide leaders in cancer control. Among the many topics to be discussed are: Help for Your Cancer Program; How to Stimulate the Interest of the Medical Profession; The Reason for a Cancer Registry; Mechanics of a Registry; and Types of Registry Reports. There is no admission or registration fee.

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PLAN A

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NEWS and ANNOUNCEMENTS (Cont'd)

problems, required record systems, and a detailed discussion of the routine laboratory procedures using radioisotopes clinically. A large number of diagrams, nomograms, charts, record forms, and data sheets are used to illustrate the subjects discussed.

The manual is available from the company at the above address.

Scholarships

A scholarship of \$150 will be given by the Association to honor Mildred M. Jordan, Head of the A. W. Calhoun Medical Library, Emory University, Georgia, for her contributions to the profession of medical librarianship. The MLA Midwest Regional Group is sponsoring two \$50 stipends, with preference given persons from the Midwest. These scholarships are open to members of the library profession who want to attend one of the courses in medical librarianship that have been approved by the Association.

The J. Alan MacWatt Scholarship of \$1,000 was presented to the Association by Lederle Laboratories, Pearl River, New York, in memory of Mr. MacWatt, who was the librarian at Lederle at the time of his death in 1963. This scholarship is offered to assist a student showing promise for medical librarianship who will be entering an A.L.A. accredited library school in the summer or fall term of 1965.

The deadline for accepting applications is March 1, 1965. Forms are available from any A.L.A. accredited library school.

Miscellaneous

Opportunities to work as child care staff members at the Illinois Soldiers' and Sailors' Children's School in Normal are now offered couples (man and wife) and single men and women.

The Children's School consists of 24 cottages

in which the children live. Its primary purpose is to provide for care, training and education of children from six to 17 years of age whose parent or parents served in the United States armed forces or who have been declared dependent or neglected under the Family Court Act. The school program is designed to promote general development of the children physically, mentally and socially through understanding of their needs.

The cottage program provides wholesome, stimulating group living experiences designed to create a normal emotional climate for children. Living with the children in the cottages are members of an understanding child care staff devoted to providing a homelike atmosphere. Each cottage is fully equipped for complete living.

Persons interested in a career as a child care staff member should write directly to the Superintendent, Illinois Soldiers' and Sailors' Children's School, Normal, Illinois.

the Illinois Department of Public Health will discontinue the performance of colloidal gold tests on spinal fluid specimens. It is the opinion of most specialists in the field of venereal disease control that the value of this procedure has diminished greatly in recent years. The performance of this test is also requested much less frequently by physicians sending specimens to our laboratories. VDRL tests and quantitative determinations of protein will continue to be made on spinal fluid specimens sent to our laboratories.

Formal groundbreaking ceremonies for the George A. Zeller Zone Center, 5327 University St., Peoria, were held last month.

Gov. Otto Kerner gave the principal address. He was introduced by Peoria Mayor Robert Day, who served as master of ceremonies. Other featured speakers were Dr. Harold M. Visotsky, director of the Illinois Department of Mental Health, and Dr. Thomas T. Tourlentes, Peoria

Effective January 1, 1965 the laboratories of

(Continued from page 330)

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Two Weeks, March 22
ESSENTIALS OF PLASTIC SURGERY, One Week, April 12
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, March 29
MANAGEMENT OF COMMON FRACTURES,
One Week, March 1
BOARD REVIEW COURSE IN ORTHOPEDICS,
One Week, April 5
PEDIATRIC SURGERY, One Week, March 22
GENERAL SURGERY, Two Weeks, April 5
THORACIC SURGERY, One Week, April 12
ADVANCES IN SURGERY, One Week, April 12
VARICOSE VEINS, One Week, March 15
ARTERIOGRAPHY, Four Days, March 30
UROLOGY, Two Weeks, April 26
VAGINAL SURGERY, One Week, April 5
BOARD REVIEW COURSE IN GYN-OB, Two Weeks, March 15
OBSTETRICS, General & Surgical, Two Weeks, April 26
BOARD REVIEW COURSE IN MEDICINE, Part II,
One Week, March 29
FLUIDS & ELECTROLYTES, One Week, April 5
DERMATOLOGY, Two Weeks, April 5
RADIOISOTOPES, Two Weeks, April 26
ANESTHESIA, Inhalation, Endotracheal, Regional,
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Obituaries

William M. Avery*, Mendota, died January 26, aged 88. He was a graduate of Rush Medical College in 1901 and was in active practice until retirement in 1961. He was an emeritus member and a member of the Fifty Year Club of ISMS.

George R. Blackstone*, Urbana, died October 13, aged 90. In 1900 he graduated from Northwestern University Medical School. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Emil Bunta*, Chicago, died February 1, aged 77. A graduate of Rush Medical College in 1914, he was on the medical staff of the Municipal Tuberculosis sanatorium for 32 years. He retired in 1952.

Alfred H. Cassidy, Evanston, died January 18, aged 55. A graduate of the University of Illinois College of Medicine in 1938, he specialized in pulmonary diseases.

Alex A. Day, California, formerly of Chicago, died January 15, aged 80. A graduate of Harvard Medical School in 1911, Doctor Day was former chairman of bacteriology of Northwestern University Medical School where he also taught for 37 years. He retired in 1949.

Dosu Doseff, Chicago, originally from Bulgaria, died January 28, aged 82. A graduate of Rush Medical College in 1909, he specialized in otolaryngology. He served as a physician for the Chicago Municipal Tuberculosis sanatorium for 35 years until his retirement in 1949.

Ruth E. V. Edwards*, Chicago, died February 8, aged 73. A graduate of Loyola University Medical School in 1922, she was a staff member of Swedish Covenant hospital until her retirement in 1946.

Edward J. Gallagher*, Chicago, died January 21, aged 53. A graduate of Loyola University Medical School in 1937, he was on the staff of Mercy and South Shore hospitals. He was also an associate professor of surgery at Stritch School of Medicine.

Maxwell Gitelson*, Florida, formerly of Chicago, died February 3, aged 62. A graduate of the State University of New York Upstate Medical Center in 1930, he specialized in psychiatry. He served as director of psychiatric services at Michael Reese hospital and as psychiatrist for the Institute of Juvenile Research, the Illinois department of mental health and the Illinois Division of criminology.

Berton W. Hole*, Missouri, formerly of Springfield, died August 4, aged 95. He was a graduate of Northwestern University Medical School in 1892 and an emeritus member and a member of the Fifty Year Club of ISMS.

William E. G. Johnson*, Homewood, died January 26, aged 67. A graduate of Chicago Medical School in 1922, he practiced medicine for 40 years until his retirement in 1962.

Ralph H. Kuhns, Chicago, died October 10, aged 74. A graduate of Rush Medical College in 1913, he specialized in psychiatry.

James M. McDonnough*, Chicago, died January 21, aged 71. A graduate of the Chicago College of Medicine & Surgery in 1916, he was a staff member and past president of St. Elizabeth's hospital.

Edna D. Montgomery, Shelbyville, died January 5, aged 83. She was a graduate of Barnes Medical College, St. Louis, in 1902.

Lester S. Reavley*, Sterling, died February 2, aged 70. In 1922 he graduated from Loyola University Medical School. He promoted and organized the Crippled Children's Clinic, was ISMS president in 1957 and 1958 and was a member of the American College of Surgeons.

James C. Redington, Jr.*, Missouri, formerly of Galesburg, died January 19, aged 71. A graduate of St. Louis University School of Medicine in 1915, he specialized in internal medicine for 44 years until his retirement in 1963. He had taught at Knox College and had been a staff member of both Cottage and St. Mary's hospitals. He was a member of the American College of Physicians and the American Heart Association, and an emeritus member of ISMS.

Carl D. Render*, Oak Park, died January 30, aged 84. A graduate of the University of Louisville School of Medicine in 1907, he practiced as a physician and surgeon for 51 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Benjamin J. Schwartz, Waukegan, died January 9, aged 72. A graduate of Northwestern University Medical School in 1916, he was retired at the time of death.

Ben C. Steinbrecher*, Riverside, died January 13, aged 60. He was a graduate of Loyola University Medical School in 1931.

Guy S. Van Alstyne*, Florida, formerly of Chicago, died January 25, aged 79. In 1912 he was a graduate of Northwestern University Medical School where he later taught surgery for many years. He was attending surgeon at both South Shore and Wesley Memorial hospitals until his retirement in 1943. Since then he had been connected with the V. A., Variety Children's hospital and Dade County Health Department in Florida. He was an emeritus member and a member of the Fifty Year Club of ISMS.

*Indicates member of Illinois State Medical Society.

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NEWS and ANNOUNCEMENTS (Cont'd)

Zone director and superintendent of Galesburg State Research Hospital.

Some 700 residents in the 14-county Peoria Zone who played an active role in seeking a zone center in the Peoria area attended.

Grading of the rolling 69.3 acre site began in October. Construction of the 218-bed comprehensive mental health center is expected to take two years.

A pretty, plucky 10-year-old girl who was critically burned in the Indianapolis Coliseum explosion that took the lives of her parents, a brother and her grandmother, is the 1965 National Easter Seal Child of the National Society for Crippled Children and Adults.

She is Barbara Staten, who survived the holocaust during the ice show at the Coliseum in which 73 persons were killed on Halloween, 1963. Barbara and another brother, John, 16, who was less severely burned, now live with an aunt and uncle on a 1,000 acre farm near Owensville, Ind.

Now almost completely recovered from crippling burns over 70 per cent of her body, Barbara's fight to live and get well provides a classic case history of how a combination of intensive rehabilitation treatment and personal courage won out over long odds.

Has medicine lost sight of the patient in its zeal to stamp out such diseases as cancer, diabetes, tuberculosis, and polio?

This question is posed in an important new book, *The Crisis in Medical Education*, by Dr. Lester J. Evans, consultant in education for the health professions at the University of Illinois Medical Center Campus, Chicago.

In the book, Dr. Evans scrutinizes medical education in the United States and gives his own ideas about future developments. Tracing the growth and development of medical education, he states that if changes are to take place in the aims of medicine, they must begin in the medical school.

The book, published by the University of Michigan Press, is based on five lectures given as the William W. Cook Lectures on American Institutions. The lectures were given at the University of Michigan last year under the general title "The University and Medicine."

The thesis of the lectures and the book, according to Dr. Evans is that "since medicine has gained phenomenally in recent decades from professional education in the university; and since medicine is now in a period of rapid development; and since much is happening outside the university to enhance the continued growth of medicine, the question is whether medicine any longer needs the university, and if so, why?"

"One answer," he added, "is emphatically that it does, but not necessarily for the same purposes as in the past. The alternative is that medical education will lapse into a mid-twentieth century form of proprietary professional education, the symptoms of which are already in evidence. Although this book is concerned with medical education, the rationale of the arguments applies to all the health professions.



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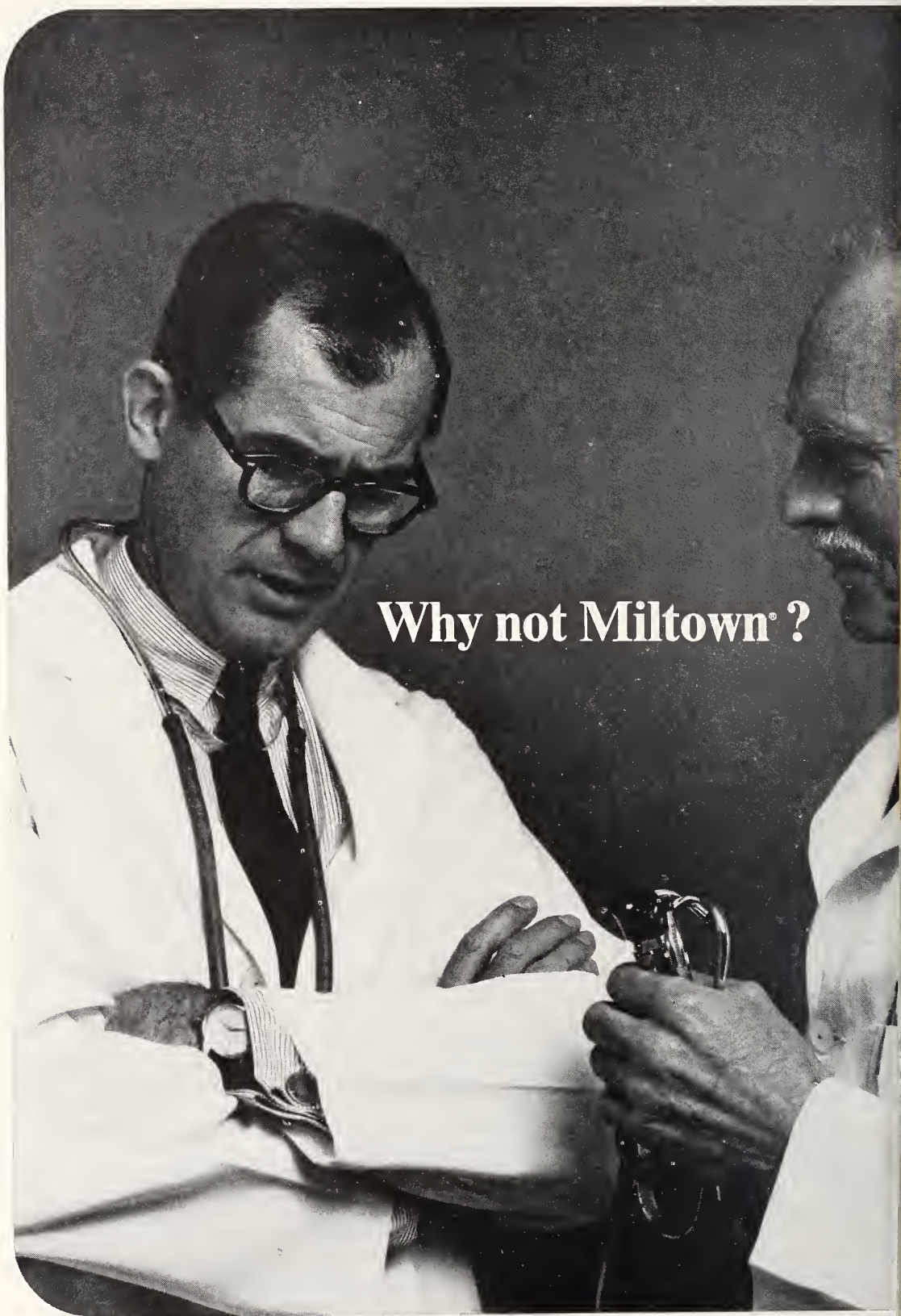
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References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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AS I SEE IT FROM '360'

By ROBERT L. RICHARDS
Executive Administrator

WHO READS ANNUAL REPORTS?

This issue is devoted to annual reports by officers and committee chairmen. These are not just for the casual reader but are published for those members who wish to know how their medical society operates and how the money is being spent.

Everyday I am told that we must communicate, communicate, communicate. There is still nothing better as a means of communication than the written word with all the details included. There is little or no emotion packed into the 90-plus pages of these reports. Efforts are continued to keep them limited in number of words but at the same time to give all the facts.

Especially noteworthy in this issue to the membership will be those reports having to do with the finances of the Society. Any member of the Society is entitled to full information on what happens to his dues. The House of Delegates always is well-informed, but it has never been made quite clear that the Board of Trustees and its finance committee have no secrets, or desire to withhold any details of which the membership should be aware.

For your personal limited reading, I suggest that a review of the report of the Chairman of the Board of Trustees and the Secretary-Treasurer would be valuable. If time is available, read all the reports and note the correlation of the committee programs all of which are important to the profession. Too often, even our members believe that scientific activities receive too little attention in the ISMS program. This is not so. The continuation of the basic purposes of the Society, established more than 100 years ago, are provided without a doubt for the interested reader of these pages.

ABSTRACTS OF BOARD ACTIONS

MEETINGS OF MARCH 13-14, 1965

REPORT ON INFORMATIONAL CAMPAIGN

All trustees reported a high degree of interest in pending health care legislation and each has participated actively in the current informational campaign. Staff directors appearing before the Board reported these highlights of the campaign:

Orientation meetings have been conducted in three target congressional districts—19th, 21st and 23rd. Speakers bureaus have been activated at the local level and thousands of residents and "opinion leaders" have been reached through various types of meetings. Auxiliary members have been active in sponsoring coffee parties, distributing literature and developing letter writing drives.

Ten outstanding speakers from outside the medical profession are filling assignments before large groups of professional and business leaders.

Radio commercials, concentrated in key congressional districts, are broadcast twice a day on 27 different stations; newspaper ads are appearing in 107 dailies and weeklies throughout Illinois; Citizens for Eldercare have distributed 10,000 Eldercare buttons, a million pieces of literature, and 2,000 posters; outdoor advertising is carried on 187 billboards throughout the state, and television commercials are broadcast on 14 stations.

The first five issues of a special newsletter were mailed to 11,200 "opinion leaders" in addition to the ISMS and Auxiliary membership. Most issues included cards, questionnaires and other educational material running the total amount of ISMS printing to more than 377,000 pieces.

NURSES EXPLAIN NEED FOR STATEWIDE SURVEY

Representatives of nursing organizations appearing before the Board presented the outline of a survey they are planning to make of the state's nursing needs and resources. It is estimated that 850,000 nurses will be needed in the nation by 1970. A study commission will be set up to study the nurse shortage as it exists, the possible sources from which additional nurses might come and the services which should be rendered by nurses. The study is expected to cost \$80,000, which is to be raised through contributions.

CONTRACT WITH STATE MUSEUM TO BE NEGOTIATED

The Board authorized contract negotiations for ISMS participation in the new Lincoln Shrine in Springfield. Under the auspices of the Archives Committee, a medical historical exhibit will be set up in the state museum.

MANUAL OF BASIC POLICY BEING DEVELOPED FOR SOCIETY

The Policy Committee has developed preliminary material for a manual containing basic policies of the Society and will present the draft to the House of Delegates in May with a request that the contents be studied for a year before any formal action is taken to publish the manual. The Board has officially accepted the preliminary material under the conditions requested by the Policy Committee.

PERUCCA REPLACES PHILIPSBORN ON PERINATAL COMMITTEE

Leo G. Perucca, M.D., was recommended to replace H. F. Philipsborn, Jr., M.D., as chairman of the Joint Committee on Perinatal Mortality following Dr. Philipsborn's resignation.

CANNADY TO REPRESENT ISMS ON COUNCIL FOR CHRONICALLY ILL

Edward W. Cannady, M.D., chairman of the Committee on Aging, has been appointed ISMS representative to the Coordinating Council for the Care of the Chronically Ill.

URGE EXPANSION OF STATE LABORATORY FACILITIES

The Board approved a resolution from the Tuberculosis Committee in support of the Illinois Department of Public Health's request for funds to expand its physical facilities which are not adequate for the examination of specimens of tubercle bacilli in the volume needed for the control of tuberculosis in Illinois.

PULSE TO BE INDEPENDENT OF JOURNAL

PULSE will be published as a separate newsletter, beginning in May. Expanded to eight pages, it will have a circulation of about 18,000 among ISMS members, the Woman's Auxiliary, medical students and paramedical personnel. It will be financed through a grant from the Roche Laboratories Division of Hoffmann-LaRoche. A new printing contract and removal of the PULSE from its pages are expected to result in some financial savings for the ILLINOIS MEDICAL JOURNAL.

GROUP MAJOR MEDICAL PLAN APPROVED

The Board approved a recommendation that the Group Major Medical Plan offered by Parker Ale-shire Co., representing the Commercial Insurance Co., of Newark, N. J., be accepted. The \$15,000 Major Medical Plan has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board the Plan will pay up to \$30 a day and up to \$45 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital, up to 90 days. The Committee was also successful in obtaining coverage for a congenital anomaly from the first day of birth after the effective date of the contract, up to \$2,000.

SUPPORT OF MEDICAL PRACTICE ACT RE-AFFIRMED

The Board re-affirmed its position in support of the strict enforcement of the Medical Practice Act. Recognizing that the shortage of physicians has caused some hospitals to employ unlicensed personnel, the Board reiterated its stand opposing this practice.

PRACTICAL NURSING BILLS SUPPORTED

On recommendation of the Legislative Committee, the Board approved in principle bills dealing with practical nursing licensure and schools and directed the Legislative Committee to continue study of bills dealing with professional nurses.

NEW AUTHORITY GIVEN CONVENTION COMMITTEE

Because the delay experienced by some specialty sections in arranging their part of the ISMS convention program has had a definite adverse effect on the sale of exhibit space and on the success of the convention as a whole, the Board ruled that any section which does not have its program set up seven months prior to the convention opening date shall lose its prerogative to provide this material and the Committee on Scientific Assembly will proceed to make necessary plans for the meeting without regard to delinquent sections.

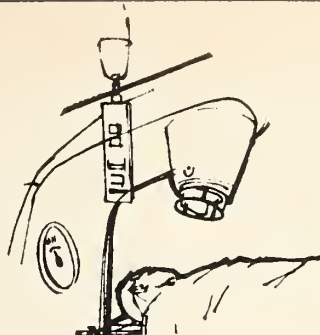
LOCAL SAMA CHAPTERS TO SPONSOR CONFERENCE

Members of the five local chapters of the Student American Medical Association will have an all-day conference and banquet May 1 at the LaSalle Hotel. Five hundred students and their wives are expected to attend.

CHANGES IN OPERATIONS OF HOUSE OF DELEGATES

Changes in operations of the House of Delegates operations will be explained to Reference Committee chairman at 10 a.m. Sunday, May 16, prior to the opening of the 1965 Convention. The first meeting of the House is scheduled for 3 p.m. that day with the Committee on Credentials meeting one hour earlier. Streamlining of nominations and elections has been approved for this session.

MEDICAL PROGRESS



HARVEY KRAVITZ M.D./progress editor

DISEASES WHICH OCCUR FREQUENTLY are familiar to practitioners and consequently present few problems in diagnosis and treatment. Less common conditions such as intestinal obstruction in the newborn are less familiar to physicians. Yet anyone in the practice of medicine and surgery may be called on to care for such patients. This paper will present some of the problems in diagnosis and treatment of neonatal intestinal obstruction.

NEONATAL INTESTINAL OBSTRUCTION: PITFALLS IN DIAGNOSIS AND TREATMENT

O. Swenson, M.D./chicago

From the Departments of Surgery, Children's Memorial Hospital and Northwestern University School of Medicine.

Pre-Delivery Warnings

There may be some information in the family and obstetrical history which can alert the attending physician to intestinal obstruction in the yet unborn child. The presence of major congenital anomalies in siblings is a warning to be on the lookout for some defect in the new baby. While it is impossible to arrive at the frequency of congenital defects in siblings, there is agreement that once a baby is born with a major anomaly the chances of subsequent siblings being affected increases to a small but definite extent. An example is Hirschsprung's disease where there is a 2-3% chance of more than one sibling being affected.¹

The second warning that may be given the attending physician is that hydramnios tends to be associated with neonatal intestinal obstruction. The explanation of this is thought to be that during intrauterine life there is considerable gastrointestinal activity and some reabsorption of fluid probably takes place. When this process is disturbed with an intestinal block it is believed that excessive amniotic fluid accumulates. While the association of gastrointestinal block and hydramnios is not invariable, the two are associated sufficiently often to be a warning to the attending physician.²

Differential Diagnosis

Unfortunately, the newborn baby with intestinal obstruction presents no obvious signs or symptoms immediately after birth. They appear and act in a perfectly normal manner. How-

ever, as ingestion of air takes place, and this is a rapid process in the first twelve hours of life, abdominal distention may develop and vomiting of bile stained material is inevitable. Many newborn babies vomit small amounts and it would be unreasonable to expect all such infants to be investigated for intestinal obstruction. On the other hand, if the vomitus is definitely bile stain, particularly if it is a brilliant green this is an absolute indication that intestinal obstruction should be given serious consideration. While this is a reliable sign, there are rare situations where the baby will exhibit this phenomena without having intestinal obstruction. The first exception is the premature infant whose gastrointestinal tract is immature and may have delayed function. The premature infant may have all the signs and symptoms of intestinal obstruction and to add to the confusion abdominal roentgenograms may outline dilated intestine. Before making a diagnosis of intestinal obstruction in the premature baby, the physician must give thought to the possibility of this being a physiologic slowing of the gastrointestinal tract. Fortunately, at 24 to 48 hours after birth, such infants begin to have intestinal function and symptoms disappear.

Another group of neonates which may appear to have intestinal obstruction are those with overwhelming sepsis. Sick infants are treated more vigorously today with antibodies and supportive therapy than 20 years ago. As a consequence more survive and at 48 to 72 hours of age, such babies may exhibit symptoms and signs consistent with intestinal obstruction, on account of intestinal ileus which is a part of the severe infection. When sepsis is suspected, blood cultures and spinal fluid cultures should be obtained promptly and if there is any indication of growth, the diagnosis of intestinal obstruction should be given secondary position in the scheme of treatment, preference being given to the treatment of the infection. The third group of patients that may have misleading signs of intestinal obstruction are infants born of mother with excessive drug ingestion. Where the mother is addicted to heroin or any of the morphine derivatives and has taken such drugs prior to or during labor there may be slowing of intestinal function in newborns to the extent that they may appear to have intestinal obstruction.

A further group of neonates which may exhibit delayed intestinal obstruction are those with a metabolic disease, such as hypothyroidism. Most important, infants with physiologic obstruction such as Hirschsprung's disease have all the appearances of intestinal obstruction. A fifth group of patients with meconium inspissation have delayed intestinal function. While the plain roentgenogram in all these situations reveals dilated intestine it is impossible to determine whether it is small or large intestinal unless a barium enema is resorted to. When a dilated or normal sized colon is outlined the diagnosis of mechanical small bowel obstruction must be abandoned.

High Intestinal Obstruction

Mechanical intestinal obstruction in the newborn should be divided into two groups: those with upper intestinal lesions and those with lower intestinal lesions. While both will vomit bile stain material, there is a difference in the appearance of these two groups of patients. The infant that has upper intestinal obstruction may have no abdominal distention or there may be some distention limited to the upper abdomen, due to the dilated stomach and duodenum. In the diagnosis of such patients, an upright and flat abdominal roentgenogram is pathognomonic.³ When this lesion is present, there is a large air bubble in the left upper quadrant which represents the air in the stomach. There will be a second somewhat smaller bubble a little lower in the abdomen and a little to the right of the midline and this represents the dilated duodenum. Rarely is it necessary to use contrast material to aid in the diagnosis of duodenal obstruction. In some situations the obstruction is partial and it may be necessary to do a contrast study with barium. The usefulness of this diagnostic maneuver becomes greater in the child of several weeks of age who is not doing well and may have partial duodenal obstruction.

Before an infant with duodenal obstruction is scheduled for surgical exploration, a barium enema should be obtained to demonstrate patency of the colon. During surgical exploration it is difficult to expose and inspect the colon particularly the retroperitoneal portions. This information can be gained far more simply by having a barium enema performed before the

exploration is undertaken.

One of the common lesions which produces duodenal obstruction is malrotation. This is a congenital malformation of the rotation of the colon associated with a narrow attachment of the mesentery of the small intestine. In this situation there may be some urgency in operating on the baby for frequently there is volvulus of the midgut and this may lead to necrosis of practically all of the small intestine, unless the situation is promptly corrected. Volvulus may produce rectal bleeding. The association of this with all the signs and symptoms of intestinal obstruction indicated a more urgent situation. There is one other pitfall in treating malrotation which should be given careful attention by the surgeon. The instance of a diaphragm or atresia associated with malrotation is of sufficient frequency to warrant the surgeon passing a tube of a size 10 or larger through the duodenum into the jejunum before dismissing the possibility of there being an intraluminal obstruction in addition to the extraluminal factors. It is possible in most instances to manipulate a nasal gastric tube down through the duodenum to clarify this point. If it is not possible it is wise to open the duodenum and to pass an adequate catheter down through to eliminate the possibility of a secondary obstruction to be present intraluminally.

The next most common lesion that produces duodenal obstruction is atresia. In this group of patients a posterior jejunoduodenostomy is preferred over an anterior jejunoduodenostomy. One must constantly keep in mind in dealing with the newborn that success in correcting the mechanical obstruction will permit a normal length of life and it has been our experience that a posterior jejunoduodenostomy functions with less complications over a long period of time than the anterior variety.

The third lesion which produces duodenal obstruction is annular pancreas. There is no accurate pre-operative method to make this diagnosis except in a neonate with duodenal obstruction and no bile in the vomitus. Obstruction of the duodenum above the Ampulla of Vater is rare and is most likely to be caused by an annular pancreas. However, most annular pancreases are below the ampulla so that this situation is rarely of help in making this anatomic diagnosis.

Low Intestinal Obstruction

In the second group of patients, the intestine is obstructed in the lower ileum or colon. Massive abdominal distention is inevitable in these neonates. One special group of patients are mentioned for completeness. These are neonates with imperforate anus and associated lesions. The diagnosis depends on careful inspection of the newborn. Frequently, there is in the males a fistula to the urinary system and in the females to the vagina. When there is an obvious fistula, the patient is no longer an emergency particularly where there is a recto-vaginal fistula and therefore, these situations do not warrant discussion within the confines of this paper. On the other hand, infants with imperforate anus without any fistula must be treated promptly as infants with intestinal obstruction. How these lesions are to be dealt with depends on the distance between the distal colon and the perineum. By taking films in the upside down position with a marker on the perineum, one can measure this distance. If it is greater than one centimeter a combined abdominal perineal operation is mandatory. If it is less than this, a perineal operation can be successfully accomplished.

The long term results in this group of patients depends to a considerable extent to the precision with which the operation is performed. It was common practice to simply bring the colon through the perineum to the skin and hope for a good result. It is now clear that by careful dissection and preservation of the puborectalis sling that superior results can be obtained. Of equal importance to the way the operation is performed is the long term follow up care.

The difficult lesions to deal with are the babies that have all the symptoms of small bowel obstruction without any obvious reason on external examination for the obstruction. The clinical diagnosis of this condition is similar to that of upper intestinal obstruction, except there will be an associated massive abdominal distention. When lower small bowel obstruction is suspected, the first diagnostic maneuver is to have a plain roentgenogram of the abdomen made in an upright and prone position. When these outline dilated loops and fluid levels considerable attention must be

given to the diagnosis of intestinal obstruction. A serious pitfall in the treatment of this group of patients is that in a plain abdominal roentgenogram of the newborn it is impossible to distinguish between large and small intestine. It is true in the older child and adult the appearance of small bowel is so different from large bowel that it can be identified with accuracy on the plain roentgenogram. This concept must be discarded in the newborn or serious mistakes can be made. The only way to determine whether the dilated loops are large intestine or small intestine in the neonate is for a barium enema to be performed. This should be the second diagnostic maneuver and should invariably precede abdominal exploration. If the barium enema reveals a microcolon, that is an unused narrow colon, then one can be absolutely sure that one is dealing with either intestinal obstruction due to atresia or band or to inspissated meconium and such lesions require operative intervention. On the other hand, should the barium enema reveal a normal sized colon or a dilated colon the diagnosis of intestinal obstruction due to mechanical lesions in the small intestine must be discarded. When the colon is small, a microcolon, abdominal exploration should then be undertaken. Atresia of the lower intestine is a common finding in such patients.⁴ One of the important points in treating this group of patients is to resect the distal 10 or 12 cm. of dilated bowel. This tremendously hypertrophied dilated bowel probably will never function properly and there has been sufficient experience clinically to substantiate the contention that unless one resects this dilated portion of bowel one may have intestinal malfunction as a serious postoperative problem. The second point to make is the disadvantages of a side to side anastomosis. The tendency in such situations is for the blind end beyond the anastomosis to dilate as the years go by and the patient may return with anemia, pain, ulceration and distention of this closed end of intestine beyond the anastomosis. For these reasons, an end to end anastomosis is mandatory. At this point, it would be timely to call attention to the fact that to do a gastrotomy in all babies with intestinal obstruction is not good practice. For many years this was not done. A simple nasal gastric tube will function very well postoperatively and has all of the

advantages of a gastrotomy and none of the disadvantages. In doing gastrostomies there are complications and the number are sufficient to more than outweigh the benefits in the routine cases of intestinal obstruction.

There is one other group of patients that one encounters with the signs and symptoms of intestinal obstruction in the newborn and that is the infant with meconium ileus. These are babies with pancreatic fibrosis with inspissation of intestinal contents to the point that intestinal obstruction is produced. At times one can detect these patients by palpation of dilated loops of intestine filled with putty like meconium. At any rate, once the abdomen is opened, there is little doubt about the diagnosis because of the inspissated material. We have found the best way to treat these is to open the bowel and evacuate as much of the semi-liquid meconium as possible utilizing hydrogen peroxide to irrigate with and then to reset a portion of dilated bowel. Washing out the narrow distal segment with hydrogen peroxide and making sure that it is patent is important and then to do an end to end anastomosis. The important thing to remember with these babies is that a high percentage of them will unfortunately be subjected to all the troubles of babies with pancreatic fibrosis or fibrocystic disease. Pulmonary lesions appear early. Consequently, it is well to institute therapy with pancreatic substitution in the feedings and to give prophylactic antibiotic therapy to protect against pulmonary infection.

Hirschsprung's Disease

The most important group of patients to detect in seeing the spectrum of infants with intestinal obstruction are those with Hirschsprung's disease or agangliosis of the distal colon.⁵ These babies appear clinically identical to a baby with intestinal obstruction. They can be separated from the babies with mechanical obstruction by the use of barium enema. Therefore in babies with signs and symptoms of intestinal obstruction who have a dilated or normal sized colon a diagnosis of Hirschsprung's disease must be given serious consideration. Unfortunately, a diagnosis of Hirschsprung's disease cannot be made by barium enema with accuracy until the baby is 6-8 weeks of age. The

only way to establish this diagnosis in this young age group is for a rectal biopsy to be performed.⁶ It is important that this biopsy be done 2 cm. above the mucocutaneous margin. One must have an experienced pathologist to examine this material by frozen section technique. When a rectal biopsy is obtained the pathologist makes frozen sections and when no ganglion cells can be identified one proceeds with abdominal exploration. If the baby is in good condition, and there is no evidence of enterocolitis one can do a resection with a pull through anastomosis as a primary operation. If the baby is not in good condition, if there has been any suggestion of diarrhea, then a colostomy should be made at the point of junction between normal and abnormal bowel.⁷ It is impossible in the neonate to select this point from the gross appearance of the intestine. We have made serious mistakes in the past in attempting to do so. Colostomy placed blindly may be in the aganglionic segment or high in the normally ganglionated colon. Consequently,

we perform a biopsy of the colon and on the basis of the frozen section findings, place the colostomy at the junction between normal and abnormally ganglionated colon. If a primary resection is to be done, it is absolutely imperative to have a frozen section made of a biopsy of the bowel so that in the reconstruction normal colon will be brought down and all of the aganglionic segment of the colon be removed.

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Musical Treat Slated For Annual Convention

•

HENRI NOEL, BARITONE

BARBARA NOEL,
MEZZO SOPRANO



Mr. Noel

Featured performers at the Annual Banquet of the Illinois State Medical Society on Tuesday, May 18th will be HENRI NOEL, a baritone who is a featured singer from the Chicago Lyric Opera Company, and his partner BARBARA NOEL.

TECHNIQUE

Always an informative technique in assessing extent of nodal disease in lymphoma and the channel disease in primary lymphedema, lymphangiography recently has gained new popularity. This article reviews the technique, clinical indications and complications of the procedure.

LYMPHANGIOGRAPHY HAS BEEN AN INFORMATIVE technique since Kinmouth introduced its use in the study of primary lymphedema.¹ There has been a burgeoning of interest in the technique in the last several years with particular emphasis applied to the staging of malignant neoplasia, notably the lymphoma group.² The following is a discussion of the technique, clinical indications, and complications of the procedures.

Technique

In 1952 Kinmouth began a study of lymph-

dema using the intralymphatic injection of Trypan Blue. Lymphangiography with this dye demonstrated the superficial lymphatics but gave so information concerning the deep lymphatics. Intra-lymphatic injection of radio-opaque contrast materail was performed, and definitive identification of the congenital abnormalities in primary lymphedema was obtained.³ The following is a description of the technique.

Into the interdigital folds between the first and second toes, 0.1 cc of Patent Blue (Alpha-zurine 2 G)* is injected intradermally. After fifteen minutes, the lymphatic channels are stained, a vivid blue. Under aseptic technique a vertical incision in the skin overlying the interspace between the first and second metatarsals above a blue stained lymphatic is made. The lymphatic channel is isolated. At this time it is of paramount importance to strip the lymphatic channel of all connective tissue. Failure to do this will prevent satisfactory cannulation. The channel is meticulously cannulated with a 27 gauge needle connected to a polyethylene catheter. It is fixed in place with a suture. At this point an infusion of 10 cc Ethiodol per extremity is performed using a constant pressure injector at a pressure of 12 psi. The duration of the infusion is from one to two hours. At the conclusion of the infusion, radiographs of the extremities, pelvis, lumbosacral spine, thoracic spine and chest are made. Delayed films of the lumbosacral spine and pelvis are taken at twenty-four hours. It is important to maintain strict aseptic conditions during the cutdown to prevent wound infection. Constant pressure, not exceeding 12 psi, must be main-

LYMPHANGIOGRAPHY

Lawrence Schlachter, M.D., and
William Heiser, M.D./chicago

Assistant Attending Staff, Chicago Wesley
Memorial Hospital. Resident, Chicago Wesley
Memorial Hospital.

*Obtained from National Aniline Division, Allied
Chemical Corporation.



FIGURE 1. AP film of the abdomen done at conclusion of injection, demonstrating normal lymphatic channels and nodes in the iliac and para-dortic position.

tained during the infusion to prevent lymphatic rupture and extravasation.

Anatomy

The anatomy of the lymphatic system has been widely discussed. The radiographic anatomy adequately demonstrated the lymph channels which usually number from 12 to 15 per extremity.⁴ The channels are usually one to three mms. in width. The beading seen along the course of the channels is due to the presence of valves. Lymph nodes are generally oval in shape with a defect along the periphery representing the lymphatic hilus. The parenchyma of the normal lymph nodes is finely reticulated. Lymph nodes in the inguinal, femoral, and iliac areas are not infrequently infiltrated with fatty or fibrous tissue which on the radiograph cannot be differentiated from metastatic involvement.⁵ Normal lymphangiograms are demonstrated in Figs. 1 and 2.

The indications for lymphangiography are generally limited to:⁶

1. Evaluation of lymphedema
2. Determination of the extent of neoplastic disease
3. Evaluation of thoracic duct abnormalities.

In the evaluation of lymphedema, arteriography and venography should be performed prior to the examination of the lymphatics to exclude abnormalities of these vessels. If venous or arterial disease is demonstrated, then the lymphangiogram will reflect evidence of secondary lymphatic disease with both nodal and channel involvement. However if these studies are normal, then the lymphangiogram will reflect only primary lymphatic channel disease.

The congenital abnormalities in the lymphatic channels consist of 1. hypoplasia, 2. aplasia, and 3. varicosities with or without dermal back flow.³

In lymphedema congenita, Milroy's disease, the lymphangiogram demonstrates aplasia of the lymphatic channels. Primary lymphedema is subdivided into the early and late form. Lymphedema praecox occurs before the age of thirty-five and the lymphangiogram demon-

FIGURE 2. AP Film of the abdomen done at 24 months post injection, demonstrating the nodal pattern more discretely.





FIGURE 3. AP Film of left hip, demonstrating hypoplasia lymph channels with normal nodal pattern. Findings are consistent with lymphedema praecox.



FIGURE 4. Lateral view of lumbosacral spine demonstrating "foamy" enlarged retroperitoneal lymph nodes. Pattern typical of lymphosarcoma.

strates hypoplastic or varicose lymphatics. Lymphedema tarda occurs after the age of thirty-five and demonstrates similar changes. If varicosities are demonstrated in the lymphatics, there may be associated dermal back flow. The term dermal back flow refers to the filling of the collateral skin lymphatics in lymphatic obstruction. In all cases of primary lymphedema there is a history of a minor trauma which precipitates the lymphedema. The reason for this appears to be an overloading of the capacity of the congenitally abnormal lymphatics with resultant lymph stasis and fibroblastic reaction. The process once initiated is self-perpetuating.⁷ Lymphedema praecox demonstrated in Fig. 3.

Lymphangiography is necessary for the accurate staging of lymphomas since 40% of the clinically staged 1 and 2 Hodgkins disease are actually Stage 3 disease with retroperitoneal adenopathy.² The rationale for the reliability of the procedure in evaluating lymphomas is the pathognomonic picture of the lymphomatous

nodal involvement. At times it is possible to subdivide the lymphoma group into lymphosarcoma and Hodgkins by their radiographic appearance. Classically the lymphosarcomatous node is an enlarged lymph node with a "foamy" parenchyma; whereas the Hodgkins node is an enlarged "foamy" node with an eccentric filling defect without involvement of the lymph node capsule. These findings are shown in Figs. 4, 5, and 6. Abnormal lymph nodes retain the contrast material up to 24 months, whereas normal nodes do not retain the contrast material for more than 3 or 4 months.⁷ This allows one to evaluate the response of involved nodes to specific therapy without repeating the lymphangiograms.

When dealing with the demonstration of metastatic carcinoma, the lymphangiogram is a less reliable procedure than the lymphangiogram in lymphoma.⁷ The reliability of the procedure depends upon the clinical correlation and the experience of the lymphangiographer. Typically, metastatic involvement of a node is



FIGURE 5. AP view of lower lumbosacral spine demonstrates the same changes as in Figure 4.

present when there is no increase in the size of the node but there is a discrete ragged filling defect in the node which destroys the adjacent lymph node capsule. Since areas of normal fatty and fibrous replacement cannot be differentiated from this appearance, the procedure has limited use in the detection of disease particularly in the inguinal, femoral, and iliac nodes. Metastatic deposits less than 5 mms. cannot be detected.⁷ Fig. 7 demonstrates the lymphangiogram in metastatic carcinoma of cervix.

Considering the abnormalities of the thoracic duct (Figs. 8 and 9), the presence of underlying lymphoma in cases of chylo-thorax or chylous ascites can be detected. Obstruction as well as laceration of the thoracic duct demonstrated by the lymphangiogram has been reported.⁶

Other clinical applications of lymphangiography as reported (11-12) have been in the de-

tection of lymphatico-calyceal fistula in chyluria, response to chemotherapy, and determination of the completeness of lymphadenectomy by staining the lymph nodes green with chlorophyllated ethiodol.

Complications

The complications of the procedure have been reported as follows:⁷

1. Wound infection
2. Post lymphangiographic lymphedema
3. Post injection fever
4. Post lymphangiographic pneumonitis
5. Extravasation of the contrast material
6. Allergic reaction
7. Pulmonary oil embolism.

The review of complications has been extensively reported.⁷ In our personal experience we have been fortunate enough to have had only

FIGURE 6. AP view of the pelvis demonstrates an enlarged right iliac node with ventral replacement. Pattern is consistent with reticulum cell sarcoma or Hodgkins.



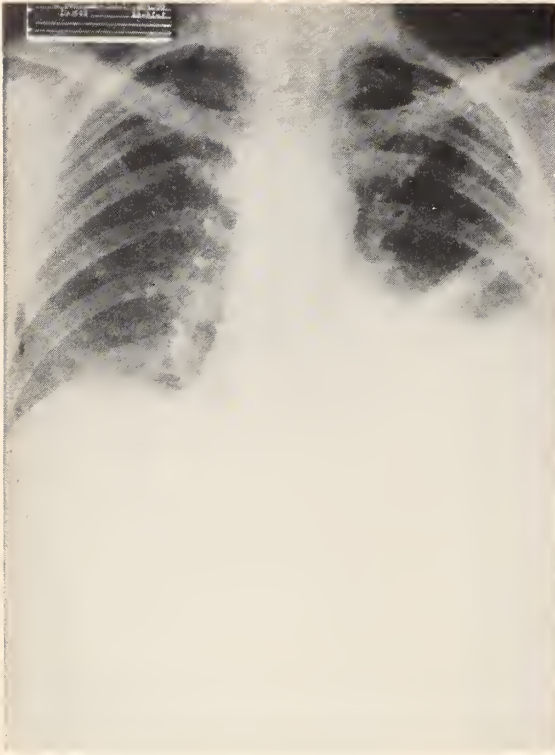


FIGURE 7. PA chest demonstrates left loculated pleural effusion chylous fluid on thoracentesis.

minor wound infection. The major and most important complication of the procedure is pulmonary oil embolism. Radiographic evidence of oil embolism is obtained in 10% of patients having the procedure.⁸ The reason that the percentage is not higher is because the lungs

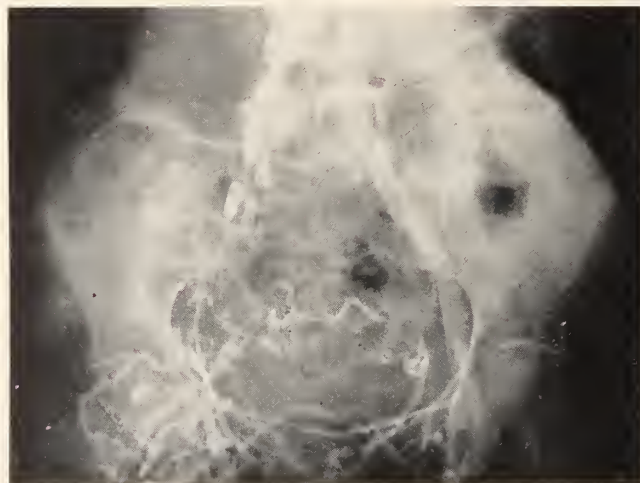


FIGURE 8. AP view of the abdomen demonstrated enlarged, foamy nodes in the patient with chylous thorax. Diagnosis of lymphosarcoma.

can normally tolerate approximately 20 ccs of contrast material.⁷

Usually pulmonary oil embolism is asymptomatic and its presence is only revealed by the

FIGURE 9. AP view of the pelvis demonstrates filling of the left femoral and common iliac veins. Obstruction of the right femoral vein with collateral circulation. Lymphangiogram demonstrates multiple filling defects in normal sized iliac and para-aortic nodes. Patient had metastatic carcinoma of the cervix.



routine chest radiograph taken at the conclusion of the procedure. However in patients with severely compromised pulmonary reserve (pulmonary emphysema, extensive pulmonary metastases, and severe pulmonary fibrosis) the oil embolism may produce morbidity or mortality. The single documented fatality resulting from lymphangiography was in a case of severe pulmonary insufficiency. Not only does compromised pulmonary reserve increase the danger of oil embolism but also extensive nodal infiltration with obstruction increases the risk. In this instance the increased risk is due to the development of lymphatic-venous collaterals

secondary to the obstruction. This results in a rapid shunting of the contrast material to the lungs with overloading of the normal reserve.⁷

Conclusion

Lymphangiography is an informative technique in assessing the extent of nodal disease in lymphoma and the channel disease in primary lymphedema. Its major complication of pulmonary oil embolism can be prevented by pre-lymphangiographic estimate of the pulmonary reserve and by early radiographs to detect obstructive retroperitoneal adenopathy.

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FOR THE PHYSICIAN:

SCREENING AND DIAGNOSIS IN DIABETES MELLITUS

R. Lincoln Kesler, M.D./chicago

DURING THE MONTH OF MAY, billboards in Chicago and throughout Illinois will call the public's attention to the dangers of undetected diabetes. The outdoor advertising campaign, initiated by the Illinois State Medical Society, is designed to alert our citizens to their need for regular blood glucose tests to detect diabetes in its early stages.

The nearly 12,000 physicians in our state will play, of course, the key role in this campaign. It is hoped that they will become sharply aware of the importance of mass blood screening programs at local, as well as state levels. These programs have proved increasingly effective in identifying likely new cases and referring them to their own physicians for retesting, diagnosis and treatment.

Diabetes mellitus is rapidly growing in prevalence and has reached new importance as a public health problem. Well-planned blood screening programs, carried out on a year-round basis in Illinois communities, can do much to alleviate this situation.

Here is a brief summary of the diabetic problem today, and what we physicians can do to help solve it. The following information is offered as a reference guide to Illinois prac-

titioners who, in the weeks ahead, will be asked by many patients, "Doctor, do I have diabetes?"

The disease is listed as the 8th cause of death. 3rd cause of blindness.

4 million or more U.S. citizens are diabetic at the present time.

2 million or more of these people are unaware that they have the disease.

22% of our present population carry the gene(s) for diabetes.

Diabetes can be detected long before it becomes symptomatic.

Simple measures can control early diabetes—if it is discovered.

Acute complications of diabetes can be prevented by early detection and treatment.

Persistent hyperglycemia and glycosuria are late manifestations of diabetes.

How To Find It Early

A 2-hour postprandial blood sugar determination is the method of choice for screening. The *fasting* blood glucose level is commonly normal in early diabetes! There is often no glycosuria in asymptomatic diabetes. The earliest sign of diabetes is an elevated blood sugar after a high carbohydrate meal.

Potential Diabetics: Those with greater than average likelihood of developing diabetes are: blood relatives of diabetics, mothers of babies weighing 9 lbs. or more at birth, progeny of diabetic parents, the obese, persons over forty years old, and pregnant women with glycosuria.

Latent Diabetics: Those persons who have abnormal glucose tolerance but *no symptoms*. Early treatment, particularly weight reduction, may forestall for years or even permanently the symptoms and complications of diabetes in these groups.

"Maturity Onset Diabetics": Those with rela-

Attending staff physician, Department of Medicine, Presbyterian St. Luke's Hospital, Chicago; Assistant Clinical Professor of Medicine, University of Illinois.

tively stable diabetes who have symptoms of varying severity which may not have brought them to their doctor. They are usually responsive to oral hypoglycemic agents.

"Juvenile Diabetics": Ordinarily, they have marked symptoms at the onset of hyperglycemia, so that they seek medical attention shortly thereafter. These patients tend to be ketosis-prone, are unresponsive to oral hypoglycemic drugs and are unstable after a year or two. Screening surveys to find undiagnosed diabetics are concentrated on finding patients in the first three categories.

Blood Tests: Blood is drawn from individuals as close to two hours postprandially as possible. If the patient has eaten more recently, the time from the last meal is noted. The blood sugar is determined by semi-automatic (Clinitron) or automatic (Autoanalyzer) machines.

Who Is Referred—The Positive Sreenee: If the blood sugar is over 130 mg. % approximately 2 hours after a meal. If the blood sugar is over 160 mg % approximately 1 hour after a meal. The individual is notified to see his private physician for retesting to determine if he is truly diabetic.

Retest 2-hour postprandial blood sugar. Every patient referred to a physician should have a *postprandial blood sugar repeated 2 hours* after a meal containing at least 100 grams of carbohydrate.

Results of repeat 2-hour postprandial blood sugar ("true" glucose values):

	Result	Diagnosis	Recommendation
I	over 140 mg. %	Diabetes Likely	Glucose tolerance test or other tests
II	110-140 mg. %	Diabetes Suspect	
III	Less than 110 mg. %	Non-Diabetic	Retest periodically

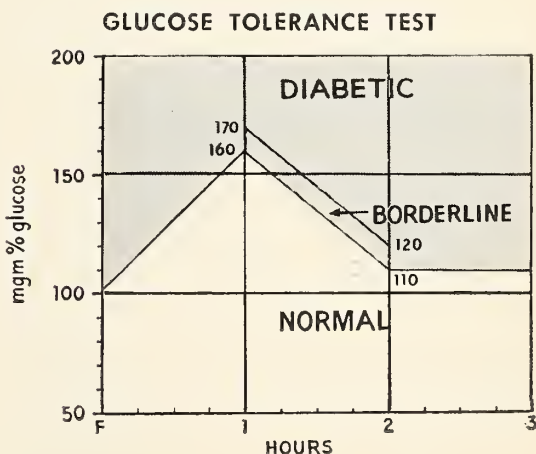
I. Provided the patient has been eating a normal diet previously, and has no other disease, a 2-hour postprandial blood sugar of over 140 mg. % suggests the presence of diabetes mellitus. Appropriate tests to establish the diagnosis are indicated.

II. Patients with blood sugars between 110 and 140 mg. % are in the doubtful range. A glucose tolerance test should be done. If the

glucose tolerance test is not definitive, a cortisone glucose tolerance test or an intravenous tolbutamide test may be done.

III. If the repeat 2-hour postprandial blood sugar is less than 110 mg. %, a definitive diagnosis cannot be made. The early diabetic may show only intermittent elevations of blood sugar. Several normal values over a period of time are needed before a single elevation (as in the screening) can be discounted. The elevated screening blood sugar represents non-diagnostic hyperglycemia, and while it may represent an error in testing, perhaps because of being done too soon after a meal, the patient requires subsequent retests periodically. This is particularly true if the patient is a pregnant female, relative of a diabetic, or other type of potential diabetic.

When the 2-hour postprandial blood sugar is 110-140 mg. % or over, a glucose tolerance test should be done.



1. The patient should have eaten a diet containing 250-300 grams of carbohydrate daily for three days, i.e. a normal diet.

2. The patient fasts after midnight preceding the day of the test.

3. A fasting blood and urine specimen are obtained.

4. A solution containing 100 grams of glucose (easily given in lemonade) is ingested.

5. Blood and urine glucose are determined at $\frac{1}{2}$, 1, $1\frac{1}{2}$,* 2, and 3 hours after ingestion of the solution.

Values consistently exceeding Column II above are diagnostic of diabetes, in the absence of

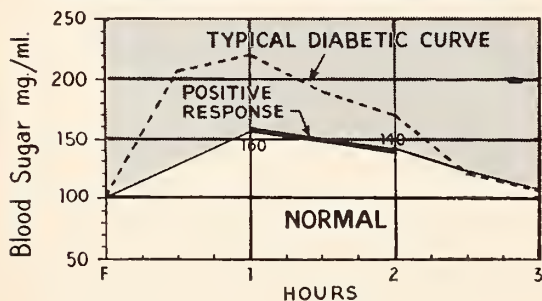
*On mildly diabetic curves, the $1\frac{1}{2}$ hr. blood glucose value should exceed 135 mg. %.

INTERPRETATION OF GLUCOSE TOLERANCE TEST

	I Normal	II Diabetic	III Borderline
FBS	100		
1 hr	160	170	160 - 170
2 hrs } 3 hrs }	110	120	110 - 120

other disease. Individual values may be elevated because of unusually slow or rapid gastric emptying. Borderline values require a repeat glucose tolerance test or use of other tests such as cortisone glucose tolerance or intravenous tolbutamide test.

CORTISONE GLUCOSE TOLERANCE TEST



1. The patient should have eaten a diet containing 300 grams of carbohydrate daily for three days.

2. 50 mg. cortisone acetate is administered orally 8½ hours and again 2 hours before glucose tolerance test if body weight is below 160 lbs.; 62.5 mg. each time if above 160 lbs.

3. A glucose load is administered orally at the rate of 1.75 grams of glucose per kilogram of ideal body weight.

4. Blood sugars are determined at 0, 30, 60, 90, and 120 minutes after glucose load.

5. Positive response:

	Blood sugar mg. %
1 hr.	160
1½ hrs.	150
2 hrs.	140

Intravenous Tolbutamide Test

1. The patient fasts for at least 9½ hours.
2. A fasting blood sugar is drawn.
3. 1.0 gram of tolbutamide is given intravenously over three minutes.

4. A blood sugar is drawn 20 minutes and 30 minutes after the intravenous tolbutamide has been given.

5. A fall in blood sugar at 20 minutes to less than 75% of the fasting level rules out diabetes. A blood sugar at 20 minutes which is more than 89% of the fasting level indicates diabetes. Values of 75-89% are equivocal.

6. 30 minute values of 77% or more are diagnostic of diabetes.

The test is based on the decreased ability of the diabetic pancreas to release insulin when stimulated by tolbutamide. The patient should be fed after the 30 minute blood sugar is drawn to prevent hypoglycemic symptoms. The test is quite reliable except during pregnancy when other hormonal factors appear to interfere.

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The View Box

LEON LOVE, M.D.

*Director, Diagnostic Radiology
Cook County Hospital*

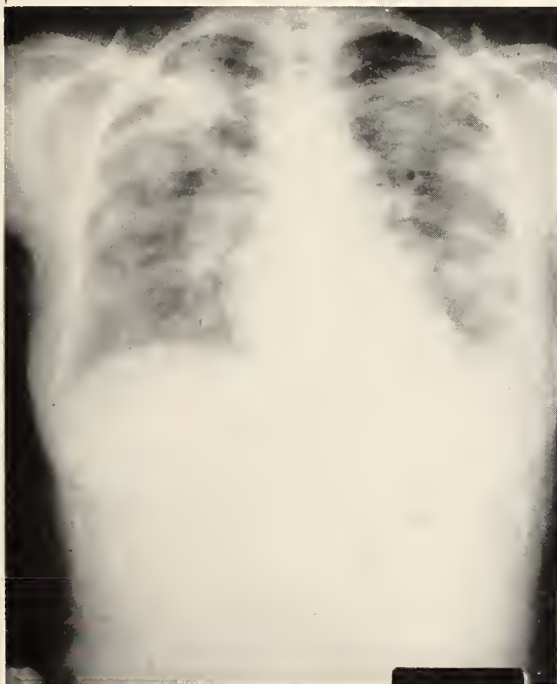


Fig. 1



Fig. 2

This 30-year-old Negro female had a routine chest examination on a mobile chest survey and was referred to the hospital for further work-up.

Physical examination revealed a well-nourished, afebrile patient with no significant physical findings. The only significant laboratory finding was a negative tuberculin test.

What is your diagnosis?

- 1) Hodgkin's Disease
- 2) Boeck's Sarcoid
- 3) Primary Tuberculosis
- 4) Metastatic malignancy

(Answer on next page)

The View Box

—diagnosis and discussion (Continued from page 373)



Fig. 3



Fig. 4

Diagnosis: Boeck's Sarcoid

Radiographic findings may be divided into three groups: 1) those with pulmonary involvement only, 2) cases with hilar and paratracheal adenopathy, and 3) those with pulmonary involvement, as well as evidence of lymphadenopathy. (Figs. 1 & 2) The so-called potato nodes, which are fairly characteristic, are large and usually involve the hilar and right paratracheal area. The pattern of lung involvement is variable, ranging from fine miliary densities to fine and coarse nodulation. Linear fibrosis may be

extensive in the later phases and may show coalescence. Large emphysematous bullae may develop. The lesion may regress spontaneously or may become progressive and eventually cause death by extensive pulmonary fibrosis and cor pulmonale. In a high percentage of cases the tuberculin test will remain negative.

In 15-25% of cases (Figs. 3 & 4) bone changes are noted, particularly in the fingers and toes. There are fine, lacy, osteoporotic changes, or areas of rarefaction or spontaneous fractures.

MAN'S ETERNAL ANXIETIES AND COMPENSATORY ILLUSIONS

Jules H. Masserman, M.D./chicago

FIRST, AS IN THE BEST of Mozart concertos, a passage of reflective humility. Although I feel deeply honored to have been chosen to present this lecture, I am fully aware that it cannot do full justice to the memory of Dr. Harold M. Camp who, until his death five years ago, had spent half a lifetime in the service of this Society and, through it, in the manifold service of mankind.

And now, if you will permit me to forego the usual "how to do it" article on psychiatric therapy, and instead accept a respectful invitation from me to "think why," I shall open with what at first hearing seem to be an irrelevant quotation from Miguel de Unamuno about the nature of man, his anxieties, and his compensatory aspirations:

"It is not rational necessity," wrote this troubled philosopher, "but *vital anguish* that impels us to believe in God."

I submit that de Unamuno comes near the heart of the matter; indeed, this essay would have been well anticipated had he but added two other truths about us: namely, that man's "vital anguish" impels not only his belief in God, but also in his sciences and in his societies. For these three flights from human anxiety, to use Biblical terms, stretch in space-time from Dan in ancient Israel when the prim-

itive Habiru used stone axes, gathered into tribes and conceived a deity we still worship, to modern Beersheba where their descendants, still in the name of Yahweh, employ the latest scientific techniques to tame their hostile milieu for the sake of social survival. Indeed, to continue the Biblical idiom, in the very beginning was the Word—and that word, then as here and now, may well have been *anxiety*. Since there is perhaps no more encompassing or protean term in the English language, not excepting the almost equally poetic concepts of *narcissism*, or *love*, a survey of the multiple meanings of *anxiety* in their philologic and historical perspectives may well be our first concern.

Concepts of Anxiety

Dictionary definitions, which reflect the semantic origins and evolutionary wealth of our language, are often more illuminating than technical strictures: Thus, the *Unabridged Oxford* notes that *anxiety* was derived from the Latin *angere*, indicating an intuitive link between destructive impulses and fear of retribution. From this sprang three derivative meanings: *vital anguish*, as bemoaned by de Unamuno, *solicitude* or empathy with a fellow-victim, and *reactive endeavor* to remove these threats, as in youth's eternal anxiety to explore and conquer. But it is relevant to all three that German *Angst*, as used by Freud, also has the echoes of limitation and constraint.

Historically once again, the ancient Hebrews had recognized the eternal struggle between Yetzer Harah (spirit of destruction) and Yetzer Hatov (good), reflected in human affairs as anxious tension, and epitomized also in the Hindu Siva *vs.* Vishnu or the Taoist Yin *vs.* Yang. Characteristically, the more arrogant West developed greater intellectual and pietistic pretensions: Socrates taught that a "rational social order" would solve all of man's anxieties, to which Aristotle added that man's knowledge of physical and biological phenomena would

Professor and Co-Chairman of Psychiatry, Northwestern University Medical School. Presented as the Harold M. Camp Memorial Lecture to the annual meeting of the Illinois Medical Society, May 20, 1964.

establish his supremacy. Eight centuries later, St. Augustine, after he himself had explored the Manichaeian mysteries and had eventually tired of various youthful satisfactions, authoritatively advised strict austerity and Ambrosian religious grace for everyone else. Predictably, most men persisted in following these counsels mainly in the breach: when anxious, they reverted to the ultimate (Ur) patterns of defense, denial or demonology: i.e., they countered with whatever technical means were at hand, or they got drunk, or they sought social securities in hypocritical human alliances, or they enslaved or exterminated each other as a way of bribing and controlling their locally conceived gods. Thus when the Black Death ravaged Europe for three hundred years (and Michelangelo confessed "no thought is born in me that has not Death engraved on it"), Christian men first tried their futile fires and philters; when these failed, Queen Elizabeth hanged anyone who dared approach Windsor Castle, Jews were slain by the tens of thousands and George Wicher (1625) chanted:

"Some streets had churches full of people weeping.

Some others Tavernes had, rude revelles keeping."

Only when the terror of the Plague and the Religious Wars abated could men resume the intellectualized self-assertions of Descartes' "*Cogito, ergo sum*" or Spinoza's gentler solipsism:

"I saw that all the things I feared, and which feared me had nothing good or bad in them save insofar as my mind is affected by them. . . . Fear cannot be without hope, nor hope without fear (for) all is Nature and God".

Pascal, despite his Jansenite mysticism was less sanguine:

"When I consider the brief span of my life, swallowed up in the eternity before and behind it, the small space that I fill, or even see, engulfed in the intimate immensity of spaces which I know not, and which know not me—I am afraid".

Subsequent emphathizers with man's dilemma compounded still other prescriptions against anxiety: Kaffka pleaded piteously with man's unknown accusers, Thoreau sought a bucolic Walden, Kant structured the universe according

to his private "categories", Schopenhauer imperiously subjugated the world to his Will and Idea, Nietzsche extolled the amoral Superman, Goethe (emulating Luther) used his inkwell to defy the Devil himself, Marx advocated revolution leading to the abolition of politico-economic controls, Comte tried to reduce all sociology to a mathematical science (and ended by worshipping his dead wife as the Supreme Goddess of a new religion), Santayna admired the "beauty" of other forms of theology, and Kierkegaard abandoned all reason in favor of an intensity of experience that was at once an acknowledgment and a defiance of a death-dealing God—an heroic stand that, minus even the comforts of faith, was also assumed variously by Sartre and the late Albert Camus. Yet man's anxieties remained.

But as physicians rather than metaphysicians, we might properly ask: what has this to do with the health and sanity of the patients we shall see in our offices today and tomorrow? Let me answer with a pedagogic parable perhaps more meaningful to us as teachers and clinicians:

Out of the Mouths of Babes

We professors are indeed fortunate in having so many students at hand ready to instruct us—a fact of which they and I often take full advantage. Accordingly, some years ago I challenged a group of intelligent third-year residents in psychiatry (pardon the redundancy; all residents at Northwestern are of course highly intelligent) (a) to ignore all I had taught them except that all behavior is, within biologic limits, adaptive, and (b) to apply this principle to the purely introspective clarification of two basic issues in human conduct:

What, in this infinitely complex and threatening universe *are* man's deepest anxieties?

Second, what comforting illusions must man long ago have evolved to make life tolerable?

To give these questions evolutionary depth, I invited my young colleagues to put themselves in the position of their paleolithic ancestors who, cursed above all other creatures with apprehensive imagery, saw every natural phenomenon as an ominous threat, every living thing, including those of his own kind, as a potential enemy, and every tomorrow as a measureless

vista of lonely, unprotected uncertainty in a universe without predictable order or mercy. What, I asked, could poor old Stone Age man think and do to save his sanity—and what have his descendants thought and done ever since?

Inasmuch as my residents were, as stated, a fairly perceptive group, I need not have been disconcerted when they first of all implied that forgetting my teachings was a relatively easy assignment, and next pointed out that setting the stage forty millenia ago was irrelevant, inasmuch as man's physical, social and cosmic insecurities were, if anything, greater now than they were then. However, in their succeeding discussions they quite spontaneously evolved a series of fundamental formulae about man's behavior that proved to be almost identical with those developed by succeeding classes in which I tried the same evocative device, and very close to those I believe all of us would reach after sufficiently searching introspection. In briefest purview, such communal contemplation, if sufficiently courageous and spohisticated, would reveal that man's three fundamental concerns, and the defensive faiths he must develop in order to avert stark terror, are these:

First, an Illusion of Physical Invulnerability and Possible Immortality: This is an immediate necessity, since injury, disease and senescence impair not only our necessary physical competence to control the material universe about us but pose the unthinkable threat and terror of death. We counter these challenges by many devices: all of medicine is a quest for strength and longevity, and in our other sciences and technologies we seek to extend our control over the physical forces that ever menace us—even though the devices we invent for this purpose so often explode in our faces.

Second, the Hope of Brotherly Love: But since we live in an increasingly crowded and dangerous world this very circumstance poses our next problem namely, that *our neighbor may pre-empt the world by exploding his gadgets in our faces before we explode ours in his.* The paradox of our transitional age therefore still is, that whereas each of us is required to call everyone else his brother, each really suspects that the other is probably his rival or just

possibly his enemy; or, put in terms of social evolution, the long-sought "missing link between solitary ape and civilized man" has long since been discovered: it is us. Hence, as an alternative to incessant warfare, social distrust must again be countered by a second wishful fantasy, to wit: *that the world really is full of friends put there to cherish and serve us.* Insofar as this hope has been effective, men have indeed expanded their allegiances from the family through the clan, tribe and nation to the hope of world brotherhood; insofar as it has failed, larger and larger alliances of men have also tried to exterminate each other—and may yet succeed. You and I put our faith, as indeed we must, in the first eventuality.*

Third and Last, our Trust in Celestial Order: But all this makes our final anxiety all the more piercing: even were we to master everything on earth and pool our capacities in a well-regimented global society, would we even then be more than an ant colony crawling about on an insignificant pebble mocked by a vast and impenetrable Cosmos hardly sensed by our puny antennae? "Perish the thought!" say we; on the contrary, our profound philosophies can explain the entire universe; or, alternatively we are the Chosen People of the God (and how different each of our specially revealed Portraits of Him) Who devised all Creation for our exclusive delectation; indeed, since He is also our Omnipotent Servant, we can secure eternal bliss by the very techniques of appeal, bribery or, (as a last resort) obedience that once worked well on our mortal parents. This statement in no way affirms or denies the "truth" of any metaphysical or theologic system; as scientists, we merely explore their origins and examine their functions.

* "To be provocative, I shall say that all normal people are metaphysicians; all have some desire to locate themselves in a "system", a "universe", a "process" transcending at least the immediate give-and-take between the individual and his environment; for all normal people the conscious lack or frustration of some such understanding (despite wide multanimity) will result in a kind of metaphysical anxiety." Crane Brenton: *The Shaping of the Modern Mind*. New York Mentor, 1953, p. 11.

PART 2 TO BE PUBLISHED IN MAY ISSUE

PUBLIC HEALTH REPORT

FURTHER DEVELOPMENTS CONCERNING THE NEW INTERNATIONAL STANDARD OF PURE TONE AUDIOMETERS

A PREVIOUS ANNOUNCEMENT was made by the Illinois Department of Public Health concerning the new, international standard for pure tone audiometers. As was announced, this standard which was proposed by the International Organization for Standardization (ISO) became effective January 1, 1965. The ISO standard was adopted by the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology and the Executive Council of the American Speech and Hearing Association to replace the American Standards Association's (ASA) reference levels.

Since the previous announcement, several suggestions and recommendations have been made by representatives of university hearing and speech centers, schools for the hearing impaired, boards of education, health agencies and audiometer manufacturers. It is the purpose of this announcement to provide the consensus regarding the transition from the ASA 1951 standard to the ISO 1964 standard.

1. *Recalibration of Audiometers* There is no immediate need to recalibrate audiometers. Recalibration can be accomplished with the least amount of confusion if it is phased into program schedules. However, it is recommended that a plan and a date be established to accomplish the transition as soon as possible.

It is worth noting that more than the usual number of audiometers will be sent for recalibration during the summer months. This increase in the volume of work may delay the return of the instrument to the program.

Recalibration will require changes of circuitry which generally cannot be done in the field or in a dealer's office. The Maico Electronics Corporation, 21 North Third Street, Minneapolis, Minnesota, and the Zenith Corporation, 6501 West Grand Avenue, Chicago, Illinois, request that their audiometers be sent directly to the factory or to their nearest dealer who will send them to the factory. The Beltone Electronics Corporation recommends the same procedure and in addition their audiometers may also be sent to Gordon Stowe and Associates, 1728 Chapel Court, Northbrook, Illinois.

As of this date, not all of the manufacturers have established a fee for recalibration to the ISO standard. You can anticipate that the cost will be somewhat greater than previous recalibrations as the change will involve more labor and a new hearing level dial.

2. *Purchase of New Audiometers* As of January 1965, audiometer manufacturers will begin production using the new standard. New audiometers will be clearly marked "Hearing Threshold Level-ISO 1964." Inquiries regarding the cost of new audiometers should be directed to the manufacturers.

3. *Recording and Reporting Hearing Levels* To facilitate the orderly transition from one standard to another, the following procedures are recommended:

a. When reporting decibel levels in writing, care should be taken to note whether the levels are based on the ASA or the ISO standard.

b. When reporting decibel levels on an audiogram, the form should be conspicuously marked with a reference to the standard. This may be accomplished by means of a rubber stamp or a printed notation.

c. When it is necessary to convert hearing levels based on the ASA standard to hearing levels based on the ISO standard, the following corrections should be *added* to the ASA hearing level at the appropriate frequency:

Frequency in cps	125	250	500	1000	1500	2000	3000	4000	6000	8000
Correction in dB	9	15	14	10	10	8.5	8.5	6	9.5	11.5

Examples:	Frequency	ASA Hearing Level + Correction	=	ISO Hearing Level
	1000 cps	ASA Hearing Level + 10	=	ISO Hearing Level
	6000 cps	ASA Hearing Level + 9.5	=	ISO Hearing Level

d. When it is necessary to convert hearing levels based on the ISO standard to hearing levels based on the ASA standard, the corrections listed in "C" above should be *subtracted* from the ISO hearing level at the appropriate frequency.

4. *Hearing Levels and the Criteria for Failing Screening Tests* Prior to the adoption of the ISO standard, a 15 dB hearing level based on the ASA standard was used almost uniformly throughout the state. The criteria for referral corresponding to this level have been failure at two of the frequencies tested at a hearing level of 20 dB or failure at one frequency tested at a level of 30 dB. Until audiometers are recalibrated to the ISO standard, these criteria should be continued.

The differences between thresholds based on the ASA standard are not equal. That is, the difference varies for different frequencies. As a consequence, there is no single ISO hearing level which corresponds to the ASA screening level of 15 dB. It is believed that multiple screening levels for the ISO standard will result in considerable confusion. Therefore, it is recommended that until new data become available for evaluation, screening based on the ISO standard should be done at a 25 dB level for all test frequencies. A child would be a candidate for referral if he failed any two frequencies at this level or any one frequency at a level of 40 dB. These levels and criteria are approximately equivalent to those based on the ASA

standard. The number of failures should be about the same.

For those who wish to use more stringent levels and criteria which correspond to the recommendations of the Committee on Identification Audiometry of the American Speech and Hearing Association, only four frequencies should be considered in the criteria for referral: 1000, 2000, 4000 and 6000 cps. It is recommended that screening be done at the 20 dB level for frequencies 1000, 2000 and 6000 cps, and at 25 dB for the frequency of 4000 cps. A child would be judged to have failed the screening if he failed to hear the 20 dB level at either 1000, 2000 or 6000 cps or if he failed to hear the 4000-cycle tone at the 25 dB hearing level in either ear.

For background information and a discussion of the ISO standard, you are referred to the article entitled "The International Standard Reference Zero for Pure-Tone Audiometers and Its Relation to the Evaluation of Impairment of Hearing." This article was published in the *Journal of Speech and Hearing Research*, Volume 7, Number 1, March 1964, pages 7-16. A limited number of reprints of this article are available from the Illinois Department of Public Health. Requests should be sent to the Division of Preventive Medicine, Hearing Conservation Section, 500 State Office Building, Springfield, Illinois. You are asked not to request a reprint if you subscribe to the journal or if a copy is available at your library.

EDITORIALS

HOSPITALIZATION OF CHILDREN AS A PSYCHOLOGICAL BENEFIT AND LEARNING EXPERIENCE

VERNON AND SCHULMAN¹ STATE that the pediatric and psychiatric journals in the past two decades emphasized the emotional upset in children following hospitalization. The authors point out that few controlled studies have been published to determine whether children are psychologically benefitted by hospitalization. Vernon and Schulman noted that 18% of the children between 6 months and four years would benefit from hospitalization, 41% would remain stable while 41% would be upset by hospitalization. The authors suggest that psychological benefit should be considered in evaluating the responses of children to hospitalization when research studies involving the institution of new techniques of hospital care are carried out. It is seem desirable that correlative studies be carried out to determine the emotional reaction of the parents to the hospitalization of their child and the effect of the emotional reaction of the parents on those of the child.

Shorter hospitalization, modern, home like, colorful rooms, longer visiting hours, television, better psychological preparation of the child for hospitalization, and allowing mothers to room in with child, have all contributed in the reduction of emotional upsets in hospitalized children. Hospitalization of children coming from unfavorable home environments into hospitals whose staffs are aware of the emotional needs of the child would be expected to result in some psychological benefit, in at least some of

the cases. This observation has been stressed by Solnit.² Mason and others³ recently mentioned hospitalization as a learning experience for the child. One way in which this idea can be further developed is to have pre-school children especially those in nursery schools include a group visit to the hospital as a part of their education. This has been done at the Children's Hospital of East Bay in Oakland, California.⁴ Unfortunately most hospitals have a policy which excludes children under twelve from visiting.

This view may enable physicians to move away from a position of defensiveness in regard to the hospitalization of the child. The physician can, therefore, be more effective in allaying the apprehension of anxious parents who are fearful of the psychologic upset of hospitalization.

The goal for all hospital personnel is to treat the patient as a whole, which includes his psychological as well as his physical well being.

Harvey Kravitz, M.D.

REFERENCES

1. Vernon, D. T.A. and Schulman, J. L.: Hospitalization as a Source of Psychological Benefit to Children. *Pediatrics*; 34: 694, 1964.
2. Solnit, A. J. Hospitalization: An aid to physical and pschol-
ogical health in childhood. *Amer. J. Dis. Child.* 99:155,
1960.
3. Mason, E. A. The Hospitalized Child—His Emotional Needs. *New England J. Med.* 272:406, 1965.
4. Through the Looking Glass. *Hospitals*; 34:47, 1960.

GOOF BALLS

RECENTLY THE TRAGIC AND PATHETIC MURDER of an elderly gentleman by three adolescents precipitated a social reaction the nature of which demands that the medical profession scrutinize some of the basic issues involved. Immediately after the act the daily press reported that the crime was committed while the three were "high" on "goof balls" and were roaming the streets looking for more. There followed almost immediately a rampaging crusade against the illicit sale of drugs; a crusade that contains within it an assumption so grossly erroneous that it is almost delusional. The implicit idea is that the use or the desire for drugs causes crimes of violence. The next step is automatic. "Let's all hate the pushers of illicit drugs since they cause all this tragedy." I would strongly recommend that we, as a profession, do not participate in this distortion. The use, or desire for, narcotics, barbiturates or amphetamines has never been demonstrated to be the sole or even principal cause of crime. The severe psychopathology which leads to non-therapeutic use of drugs can often be demonstrated to be sufficient cause for crimes of violence.

Are we splitting hairs in making this kind of distinction? There are several reasons why we think we are not.

First of all, though it is more comfortable to pin all our social woes on those "bad people" who are "so unlike us" and who live in the penumbra of the underworld, we must give up this comfort when it is keeping us from experiencing the truth. The truth is that the youngsters who become addicted are invariably already suffering from severe though possibly not clamorous psychopathology. This psychopathology is not the result of the addiction. It is the principal cause for it. Let's not allow the zealous and justified prosecution of the dope

peddler to lull us into complacency about discovering the complex causes of an illness which is more often destructive to the bearer than to those around him. We wonder too, if there might not have been one less participant in this recent tragedy, had our society been able to implement the recommendations for psychiatric care made earlier in one boy's life.

Secondly, we *already* find an uneasiness beginning to show itself among the parents of children who must use amphetamine-like drugs or barbiturates therapeutically over prolonged periods of time. To dispel doubts one could simply cite the literature and the successful uses of large doses of benzedrine in hyperactive retarded children. The more important point, however, is that still another factor has been introduced into popular lay knowledge which will deflect parental attention from basic relationships in the family and to project the cause of difficulties on to external events.

Lastly, the physician's position must be that of pointing to truth as we know it. Though we are not social scientists and cannot assume the responsibility for implementing social reforms, the profession has always been generous in offering its findings to other professional groups for use in social welfare. If we are to continue to do so effectively we must look for truths and avoid being swept along by popular crusades that may be only tangential to the real problem. Certainly we must not underestimate the insidious destructiveness of people like pushers and by all means let us applaud every effort to rid our society of such wrong doers. But let us also keep our concepts of cause and effect clear, even if they may not be currently in vogue.

Henry P. Coppolillo, M.D.

Program Summary— ISMS Convention

Sunday, May 16

- 10:00 a.m.—Reference Committee Chairmen
Gold Coast Room 111
- Noon—Board of Trustees Luncheon
Ruby Room 113
- 1:00 p.m.—Registration for Delegates and Officers
Mezzanine
- 2:00 p.m.—Credentials Committee
Louis XVI Room
- 3:00 p.m.—House of Delegates
Louis XVI Room
- 4:30 p.m.—Auxiliary Registration
Mezzanine
- 6:00 p.m.—Buffet Supper for Delegates and
Auxiliary Board
George Bernard Shaw Room
- 7:30 p.m.—Reference Committees:
Administration
Old Chicago Room 101
Publications and Scientific Services
Holiday Room 105
Economics and Insurance
Orchid Room 106
Legislation and Public Affairs
French Room 107
Constitution and Bylaws
Life Room 108
Public Relations
Time Room 110
Miscellaneous Business
Gold Coast Room 111

Monday, May 17

- 7:30 a.m.—Auxiliary Registration
Mezzanine
- 8:00 a.m.—Board of Trustees Breakfast
Ruby Room 113
- 8:30 a.m.—Registration
Mezzanine
- 8:30 a.m.—Auxiliary Board Meeting
Orchid Room 106
- 9:00 a.m.—Internal Medicine Panel
Gold Room 114
- 9:00 a.m.—Opening of Auxiliary Meeting
George Bernard Shaw Room
- 9:00 a.m.—Illinois Obstetrics and Gynecological
Society
Crystal Room

- 9:00 a.m.—Occupational Health Panel
Old Chicago Room 101
- 9:00 a.m.—Public Aid Forum
Louis XVI Room
- 11:00 a.m.—Formal Opening of Exhibit Hall
Mezzanine
- 12:30 p.m.—Impartial Medical Testimony Luncheon
Old Chicago Room 101
- 1:30 p.m.—Section on Surgery with Illinois
Surgical Society
Ballroom
- 1:30 p.m.—Section on Anesthesiology
Gold Room 114
- 1:30 p.m.—Section on Neurology and Psychiatry
Louis XVI Room
- 4:00 p.m.—IMPAC Annual Meeting
Old Chicago Room 101
- 6:00 p.m.—Past Presidents Dinner
Starlight Room
- 6:00 p.m.—Public Affairs Dinner
Bal Tabarin

Tuesday, May 18

- 7:30 a.m.—Auxiliary Registration
Mezzanine
- 8:00 a.m.—Board of Trustees Breakfast
Ruby Room 113
- 8:00 a.m.—Auxiliary Breakfast and Second
Delegate Session
George Bernard Shaw Room
- 8:30 a.m.—Registration
Mezzanine
- 8:30 a.m.—Section on Dermatology
Old Chicago Room 101
- 8:30 a.m.—Section on Obstetrics and Gynecology
Crystal Room
- 9:00 a.m.—Section on Allergy
Louis XVI Room
- 10:00 a.m.—Illinois Association of Physicians
Jade Room 103
- 10:45 a.m.—Joint Meeting:
Dermatology and Radiology
Old Chicago Room 101
- 11:00 a.m.—Illinois Chapter, American College of
Chest Physicians
Gold Room 114
- 12:30 p.m.—Chest Physicians Luncheon
Gold Room 114

12:30 p.m.—Fifty Year Club Luncheon
Louis XVI Room

1:30 p.m.—Section on Public Health
Ruby Room 113

1:30 p.m.—Section on Radiology
Crystal Room

1:30 p.m.—Section on Physical Medicine and
Rehabilitation
Old Chicago Room 101

3:00 p.m.—House of Delegates
Ballroom

7:00 p.m.—Reception
Louis XVI Room

8:00 p.m.—Annual Banquet
Ballroom

Wednesday, May 19

7:30 a.m.—Auxiliary Registration
Mezzanine

8:00 a.m.—Board of Trustees Breakfast
Ruby Room 113

8:30 a.m.—Registration
Mezzanine

8:30 a.m.—Joint Meeting:
EENT and Pathology
Gold Room 114

8:30 a.m.—Section on Pediatrics
Louis XVI Room

8:30 a.m.—Auxiliary Parliamentary Session
George Bernard Shaw Room

9:00 a.m.—Auxiliary Second Delegate Session
George Bernard Shaw Room

12:30 p.m.—Illinois Academy of General Practice
Luncheon
Old Chicago Room 101

12:30 p.m.—Illinois Chapter, American Academy
of Pediatrics Luncheon
Gold Room 114

1:00 p.m.—Auxiliary Installation Luncheon
Bal Tabarin

2:00 p.m.—Camp Lecture
Ballroom

3:00 p.m.—House of Delegates
Ballroom

3:00 p.m.—Auxiliary Board Meeting
Orchid Room 106

3:00 p.m.—Internal Medicine Panel
Louis XVI Room

6:00 p.m.—Board of Trustees Dinner
Gold Room 114
Meeting of AMA delegates following
adjournment of Board

REFERENCE COMMITTEE MEETINGS

Sunday, May 16	7:30 P.M.
Administration	Old Chicago Room 101
Publications and Scientific Services	Holiday Room 105
Economics and Insurance	Orchid Room 106
Legislation and Public Affairs	French Room 107
Constitution and Bylaws	Life Room 108
Public Relations	Time Room 110
Miscellaneous	Gold Coast Room 111

BOARD OF TRUSTEES MEETINGS

Sunday, May 16	Luncheon	Noon	Ruby Room 113
Monday, May 17	Breakfast	8:00 a.m.	Ruby Room 113
Tuesday, May 18	Breakfast	8:00 a.m.	Ruby Room 113
Wednesday, May 19	Breakfast	8:00 a.m.	Ruby Room 113
Wednesday, May 19	Dinner	6:00 p.m.	Gold Room 114

THIS PROGRAM

. . . is acceptable for continuation study credit by the American Academy of General Practice.

Convention Program by Days

INTERNAL MEDICINE

Monday, May 17 Gold Room 114

Chairman: Roy J. Philipp, M.D., Carbondale

Secretary: Angelo P. Creticos, M.D., Chicago

9:00 A.M. "Recent Advances in Reproductive Endocrinology"—Panel

Moderator: Robert J. Ryan, M.D., Associate Professor of Medicine, University of Illinois and Chief, Endocrine Clinic, Research and Education Hospital

Panelists: Jay Gold, M.D., Associate Professor of Medicine, Chicago Medical School

Neena Schwartz, M.D., Associate Professor of Physiology, University of Illinois

ILLINOIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Monday, May 17 Crystal Room

9:00 A.M. Business Meeting

9:30 A.M. Case Reports

10:00 A.M. "Maternal Mortality Report"

John Rendok, M.D., Illinois Department of Public Health

10:30 A.M. "Ruptured Uterus With Delayed Treatment"

W. R. Maloney, M.D., Carbondale

Allan G. Bennett, M.D., Carbondale

11:00 A.M. "Medical Management of Chronic Hypertension During Pregnancy"

John W. Pollard, M.D., Urbana

Thomas R. Wilson, M.D., Urbana

Discussant: Hugh C. Falls, M.D., Lake Forest

11:30 A.M. "Analysis of Common Denominators in Maternal Mortality"

John Rendok, M.D.

Noon Luncheon—Jade Room 103

2:00 P.M. "Comments on the Treatment of Trophoblastic Disease"

Robert B. Wilson, M.D., Chief, Section of Obstetrics and Gynecology, Mayo Clinic, Rochester, Minn.

3:00 P.M. "Urologic Complications of Uterine Prolapse"

Peter J. Coughlin, M.D., Peoria

3:30 P.M. "Observations on the Population Problem and Methods of Control"

E. Harold Ennis, M.D., Springfield

OCCUPATIONAL HEALTH

Monday, May 17 Old Chicago Room 101

Chairman: Edward C. Holmblad, M.D.

9:00 A.M. "AMA Occupational Health Orientation"

Henry Howe, M.D., Director

AMA Department of Occupational Health

9:10 A.M. "Physician Responsibilities in Occupational Health Problems in Small Plants"

Clare Schwartz, R.N., Occupational Health Nursing Consultant, Employers' Mutual of Wausau

Mildred Moore, R.N., Occupational Health Nursing Consultant, Illinois Department of Public Health

Richard Sutter, M.D., AMA Council on Occupational Health

10:00 A.M. "Absenteeism in Industry"

David Joe Smith, M.D., Medical Director, U.S. Steel Corporation, Southworks

10:30 A.M. "Workmen's Compensation"

"The Interpretation of X-rays"

Arthur J. Petersen, M.D., Radiologist, Roseland Hospital, Chicago

"Disability Evaluation"

Henry Apfelbach, M.D., Orthopedic Surgeon, Chicago

"Compensation Claims

(Insurance Company-Doctor)"—Panel

Moderator: Roy Harley, Travelers' Insurance Co.

Panelists William C. Carrier, Hartford Accident Indemnity Co.

William Schmeiser, Lumberman's Mutual Casualty Co.

ADVISORY COMMITTEE TO DEPARTMENT OF PUBLIC AID

Monday, May 17 Louis XVI Room

Chairman: Fred A. Tworoger, M.D.

9:00 A.M. "Let's Talk About Public Aid—An Open Forum"

Moderator: Harold O. Swank, Director, Illinois Department of Public Aid

SURGERY

Monday, May 17

Ballroom

Chairman: Harold V. Norris, M.D., Jacksonville
Secretary: James A. Rooney, Oak Park

1:30 P.M. "Surgical Diseases of the Thyroid Gland"—Panel

Moderator: Robert J. Baker, M.D.

Panelists:

"Management of Thyrotoxicosis"

Sheldon Waldstein, M.D.

"Thyroid Nodule"

Charles B. Puestow, M.D.

"Thyroiditis"

Robert L. Schmitz, M.D.

"Complications of Secondary Thyroidectomy"

Manuel E. Lichenstein, M.D.

2:30 P.M. "Benign Lesions of the Esophagus"

O. Theron Clagett, M.D., Professor of Surgery,
Mayo Foundation, Rochester, Minnesota

3:30 P.M. "Management of Post-operative

Complications in General Surgery"

Moderator: Robert J. Freeark, M.D.

Panelists:

"Pulmonary"

Hiram T. Langston, M.D.

"Embolism, Pulmonary and Vascular"

Ormand C. Julian, M.D.

"Venous Pressure Monitoring as Guide for Shock"

Vincent J. Collins, M.D.

"Wound Infections"

Joseph Silverstein, M.D.

Co-sponsored by the Illinois Surgical Society.

All members of the medical profession invited to all sessions. No registration fee.

ANESTHESIOLOGY

Monday, May 17

Gold Room 114

Chairman: Vincent J. Collins, Chicago

Secretary: John T. Nelson, Elgin

1:30 P.M. "Propanidid—A New Short-Acting Intravenous Non-Barbituate"

Imre A. Illes, M.D., Illinois Masonic Hospital, Chicago

"Effects of Anesthesia and Surgery on Liver in Man"

John R. Torgerson, M.D., A. W. Holmes, M.D.,
P. W. Searles, M.D., and T. L. Ashcraft,
M.D., Presbyterian-St. Luke's Hospital, Chicago

"Anesthetic Properties of 1-1-1 Trifluoroethyl Chloride"

Morton Shulman, M.D., Research and Education Hospital, University of Illinois

"Economic Trends in Anesthesia"

Arthur T. Shima, M.D., Oak Park

"Intravenous Methohexital As A Supplement"

Myron J. Levin, M.D., and Richard Thomason, M.D., Hines V.A. Hospital

"Caudal Anesthesia in Obstetrics"

Herbert M. Epstein, M.D., Evanston Hospital

"Immediate Responses to Asphyxia and Its Components"

Mogens Kristoffersen, M.D., Duncan Holaday, M.D., and C. C. Rattenborg, M.D., University of Chicago

"Manual Technic for Intermittent Negative Pressure Breathing"

Alon P. Winnie, M.D., Vincent J. Collins, M.D., Cook County Hospital

3:00-3:45 P.M. Exhibit Break

3:45 P.M. "Pressure Breathing and

Respiratory Compliance"

Meyer Saklad, M.D., Providence, R.I.

NEUROLOGY AND PSYCHIATRY

Monday, May 17

Louis XVI Room

Co-sponsored by:

Chicago Neurological Society

Illinois Psychiatric Society

Central Neurosurgical Society

Chairman: Louis D. Boshes, M.D., Chicago

Secretary: Harold E. Himwich, M.D., Galesburg

1:30 P.M.

A. "Neurology—1965"

"Adult Neurology"

Sidney Schulman, M.D., University of Chicago;
Albert Merritt Billings Hospital, Chicago

"Child Neurology"

J. Gordon Millichap, M.D., Northwestern University; Children's Memorial Hospital, Chicago

B. "Neurosurgery—1965"

Eric Oldberg, M.D., University of Illinois;
Presbyterian-St. Luke's Hospital, Chicago

C. "Psychiatry—1965"

I. Adult Psychiatry

"Mental Health—March to Excellence"

Harold M. Visotsky, M.D., Director, Illinois Department of Mental Health

"The Discharged Mental Patient—Follow-up"

Jackson A. Smith, M.D., Loyola University
Discussant: Werner Tuteur, M.D., Elgin State Hospital

"Marital Disorders—Management"

Bernard L. Greene, M.D., University of Illinois;
Forest Hospital, Des Plaines

II. Adolescent Psychiatry

"The Teen-Ager"

Raymond E. Robertson, M.D., Special Assistant, Illinois Department of Mental Health, Liaison Officer to the Illinois Youth Commission

III. Child Psychiatry

Jerome L. Schulman, M.D., Northwestern University; Children's Memorial Hospital

IMPAC ANNUAL MEETING

Monday, May 17 Old Chicago Room 101
4:00 P.M.

PAST PRESIDENTS' DINNER

Monday May 17 Starlight Room
6:00 P.M.

PUBLIC AFFAIRS DINNER

Monday, May 17 Bal Tabarin
6:00 P.M.

"Are We Sufficiently Concerned?"

Edward R. Annis, M.D., Immediate Past President, Americal Medical Association

ANNUAL CLINICAL AND SCIENTIFIC MEETING OF THE

ILLINOIS SURGICAL SOCIETY

MONDAY, MAY 17

Surgical Clinics at the

Cook County Hospital—7th Floor

Harrison and Wood Streets, Chicago

Chairman: Kent Barber, M.D.

Surgical Amphitheater

8:00-9:30 A.M.

Moderator, Karl A. Meyer, M.D.

"Surgical Management of Biliary Obstruction"

Surgeon, Manuel E. Lichtenstein, M.D.

"Operative Cholangiography"

John T. Reynolds, M.D.

"Choledochoduodenostomy to Prevent Residual Stones"

E. Lee Strohl, M.D.

9:30-11:00 A.M.

Moderator, Kent Barber, M.D.

"Gastrectomy for Peptic Ulcer"

Surgeon, Peter A. Rosi, M.D.

"Management of Acute Obstruction of Afferent Loop Following Gastrectomy"

T. Howard Clarke, M.D.

"Dumping Syndrome"

Morris T. Friedell, M.D.

Hektoen Institute

11:00-12:00 Noon

"Hiatus Hernia"

Presentation of Cases and Discussion, O. Theron Clagett, M.D., Rochester, Minnesota. Professor of Surgery, Mayo Foundation, Attending Surgical Staff of Methodist and St. Mary's Hospitals, Secretary of the American Board of Thoracic Surgery

Opr. Room "A"

8:30-10:30 A.M.

Moderator, Frederic A. dePeyster, M.D.

"Surgery for Obstructing Lesions of the Colon"

Surgeon, Robert J. Baker, M.D.

"Inflammatory Lesions of the Colon"

R. Kennedy Gilchrist, M.D.

"Current Concepts in Surgical Treatment of Carcinoma of the Lower Colon and Rectum"

Charles E. Pope, M.D.

Opr. Room "B"

8:30-10:30 A.M.

Moderator, Louis P. River, M.D.

"Sequence of Treatment for Breast Cancer"

Surgeon, John W. Tope, M.D.

Radiology, David Lochman, M.D.

Chemotherapy, Isaac Lewin, M.D.

Opr. Room "C"

8:00-10:30 A.M.

Moderator, William H. Requarth, M.D.

"Reconstruction of the Injured Hand"

Surgeon, John A. Boswick, M.D.

Discussion by Burton C. Kilbourne, M.D. and J. D. Frackelton, M.D.

Opr. Room "D"

8:00-10:30 A.M.

Moderator, Geza deTakats, M.D.

"Surgery for Occlusive Diseases of the Femoral Artery"

Surgeon, Robert J. Freeark, M.D.

"Endarterectomy"

John L. Keeley, M.D.

"Role of Sympathectomy in Treatment"

W. James Gillesby, M.D.

Opr. Room "E"

8:00-10:00 A.M.

Moderator, Everett P. Coleman, M.D.

"Abdominal Hysterectomy"

Surgeon, Walter J. Reich, M.D.

"Surgical Management of Endometriosis"

Mitchell J. Nechtow, M.D.

"Hormonal Management of Endometriosis"

James W. Hamilton, M.D.

East Classroom

8th Floor

Moderator, William M. McMillan, M.D.

"Use of Implanted Pacemaker in Treatment of A-V Heart Block"

(Motion Picture) With Case Presentation and Discussion

Surgeon, Milton Weinberg, Jr., M.D.

"Complications From Implanted Pacemaker"

ALL OFFICERS, TRUSTEES and DELEGATES

are requested to attend ceremonies opening the

1965 CONVENTION EXHIBITS

11:00 a.m.

Mezzanine

May 17

DERMATOLOGY

Tuesday, May 18 Old Chicago Room 101

Chairman: H. J. Burstein, M.D., Decatur

Secretary: Louis Rubin, M.D., Rockford

8:30 A.M. "Digital Myxoid Cysts"

Hyman J. Burstein, M.D., Decatur

8:45 A.M. "The Course of Nevii"

Otto C. Stegmaier, M.D., Moline

9:00 A.M. "Cosmetics in Dermatology"

Adolph Rostenberg, Jr., M.D., Professor and Head of the Department of Dermatology, University of Illinois

9:30 A.M. "What's New About Psoriasis?"

Francis W. Lynch, M.D., Professor and Director, Division of Dermatology, University of Minnesota

10:00-10:45 A.M. Exhibit Break

10:45 A.M. Joint Meeting with Radiology

"Therapy of Skin Carcinoma"—Panel

Moderator: Francis W. Lynch, M.D., Professor and Director, Division of Dermatology, University of Minnesota

Panelists: Hugh A. Johnson, M.D., surgeon, Rockford

David J. Lochman, M.D., radiotherapist, Chicago

Hilliard M. Shair, M.D., dermatologist, Quincy

OBSTETRICS-GYNECOLOGY

Tuesday, May 18 Crystal Room

Chairman: Paul A. Raber, M.D., Decatur

Secretary: Alan Sampson, M.D., Oak Park

8:30 A.M. "Death in the Delivery Room"—

Panel

Moderator: Matthew Bulfin, M.D.

Panelists: Hugh Falls, M.D., obstetrician

Arthur T. Shima, M.D., anesthesiologist

Allison Burdick, Jr., M.D., generalist

10:00 A.M. "Management of Myoma"

William F. Mengert, M.D., Professor and Head of the Department of Obstetrics and Gynecology, University of Illinois

11:00 A.M. "Management of Ruptured

Amniotic Membranes"

Augusta Webster, M.D.

Discussants: Robert R. Hartman, M.D., Jacksonville

Merrill Huffman, M.D., Urbana

12:15 P.M. "State Report on Maternal Deaths—1964"

John Rendok, M.D., Illinois Department of Public Health

ALLERGY

Tuesday, May 18 Louis XVI Room

Chairman: Arthur H. Rosenblum, M.D., Chicago

Secretary: John Hyde, M.D., Oak Park

9:00 A.M. "Serotyping of Human

Lymphocytes for Kidney Transplantation"

Paul I. Terasaki, Ph.D., Associate Professor of Surgery, University of California, Los Angeles

Discussant: Friedrich Deinhardt, M.D., Associate Professor of Microbiology, University of Illinois

10:00-11:00 A.M. Exhibit Break

11:00 A.M. "Milk Hypersensitivity"—Panel

Moderator: Max Samter, M.D., Professor of Medicine, University of Illinois

Panelists: Armond S. Goldman, M.D., Assistant Professor of Pediatrics, University of Texas at Galveston

Robert W. Boxer, M.D., Instructor in Medicine, University of Illinois

Sidney Saperstein, Ph.D., Supervisor of Microbiology, Borden Company, Elgin

ILLINOIS PHYSICIANS ASSOCIATION

Tuesday, May 18 Jade Room 103

Chairman: Werner Tuteur, M.D., Elgin

10:00 A.M. "The Zone Concept of the Illinois Mental Health Department"

Arthur A. Woloshin, M.D., Director, Charles F. Read Zone Center, Chicago

RADIOLOGY

Tuesday, May 18 Crystal Room

Chairman: Frederic D. Lake, M.D., Chicago

Secretary: Howard C. Neucks, M.D., Urbana

10:45 A.M. Joint Session with Dermatology

"Therapy of Skin Carcinoma"—Panel

Moderator: Francis W. Lynch, M.D., Professor and Director, Division of Dermatology, University of Minnesota

Panelists: Hugh A. Johnson, M.D., surgeon, Rockford

David J. Lochman, M.D., radiotherapist, Chicago

Hilliard M. Shair, M.D., dermatologist, Quincy

1:30 P.M. "Roentgenology of the Diaphragm"

John A. Campbell, M.D., Professor and Chairman of the Department of Radiology, Indiana University

2:30-3:00 P.M. Exhibit Break

3:00 P.M. Business Meeting

3:15 P.M. Film Interpretation Panel

Moderator: John A. Campbell, M.D.

Panel: Glen Dobben, M.D., Assistant Professor of Radiology, University of Chicago Clinics
Erwin M. Janzen, M.D., Radiologist, St. John's Hospital, Springfield

Harold Matthies, M.D., Associate in Radiology, Northwestern University, Chicago Wesley Memorial Hospital

Frank A. Winters, M.D., Radiologist, St. Mary's Hospital, Decatur

5:00 P.M. Reception—Gold Room 114

ILLINOIS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Tuesday, May 18 Gold Room 114

10:30 A.M. "Discussion of Diagnostic

Problems in Pulmonary Disease"—Panel

Moderator: Gordon Snider, M.D., Associate Professor of Medicine, Chicago Medical School

Panelists: Benjamin Felson, M.D., Professor and Director, Department of Radiology, University of Cincinnati

Robert W. Carton, M.D., Associate Professor of Medicine, University of Illinois College of Medicine

William Lees, M.D., Associate Clinical Professor of Surgery, Loyola University

12:30 P.M. Luncheon—Gold Room 114

"Alveolar and Interstitial Patterns in the Lung"

Benjamin Felson, M.D.

FIFTY YEAR CLUB

Tuesday, May 18 Louis XVI Room

12:30 P.M. Luncheon

PUBLIC HEALTH AND PREVENTIVE MEDICINE

Tuesday, May 18 Ruby Room 113

Chairman: John B. Hall, M.D., Chicago

Secretary: Charles A. Lang, M.D., Wheaton

1:30 P.M. "Fragmentation of Community

Health Services"—Panel

Harold M. Erickson, M.D., Deputy Director, California Department of Public Health

Discussants: Arthur G. Baker, M.D., Director, Lake County Health Department, Waukegan

PHYSICAL MEDICINE AND REHABILITATION

Tuesday, May 18 Old Chicago Room 101

Chairman: H. Worley Kendell, M.D., Peoria

Secretary: Y. T. Oester, M.D., Chicago

1:30 P.M. "Physical Medicine and

Rehabilitation Researches in Geriatrics"

Herbert A. Schoening, M.D., Kenny Institute, Minneapolis, Minn.

"Physical Medicine and Rehabilitation in Action for Patients Above Fifty" (The Dynamic

Physical Psycho-Social Economic Prescription)

Michael M. Dasco, M.D., Professor of Physical Medicine and Rehabilitation, New York University

"Orthotics in Physical Medicine"

(Application in Geriatric Problems)

Robert L. Bennett, M.D., Medical Director,

Georgia Warm Springs Foundation, Warm Springs, Ga.

EENT AND PATHOLOGY

Wednesday, May 19 Gold Room 114

EENT Chairman: Roland I. Pritikin, M.D., Rockford

EENT Secretary: Emanuel M. Skolnik, M.D., Chicago

Pathology Chairman: Joseph D. Boggs, M.D., Chicago

Pathology Secretary: J. Robert Thompson, M.D., Chicago

8:30 A.M. "Lumps in the Neck"—Panel

Moderator: Emanuel M. Skolnik, M.D.

Panelists: Lorenz E. Zimmerman, M.D., Armed Forces Institute of Pathology, Washington, D.C.

John J. Conley, M.D., Professor of Head and Neck and Plastic Surgery, Columbia University, New York City

Edwin Liebner, M.D., Associate Professor of Radiology, University of Illinois

Joseph D. Boggs, M.D., Associate Professor of Pathology, Northwestern University and Director of Laboratories, Childrens Memorial Hospital

10:00-10:45 A.M. Exhibit Break

10:45 A.M. "Swellings of the Orbit"—Panel

Moderator: Emanuel M. Skolnik, M.D.

Panelists: Charles Iliff, M.D., Baltimore, Md. Lorenz E. Zimmerman, M.D.

John J. Conley, M.D.

Edwin Liebner, M.D.

PEDIATRICS

Wednesday, May 19 Louis XVI

Chairman: Ellis H. Harris, M.D., Glencoe

Secretary: Paul P. Pierce, M.D., Alton

8:30 A.M. "Spontaneous Resolution of

Common Endocrinopathies in Pediatric Practice"

I. Pat Bronstein, M.D., Professor of Pediatrics and Head of Pediatric Endocrinology, University of Illinois

"Can the Busy Pediatrician Contribute to Mental Health?"

Lewis M. Fraad, M.D., Professor of Child Health; Acting Chairman, Department of Pediatrics, Albert Einstein College of Medicine, New York

"Tuberculosis in Childhood"

J. A. Meyers, M.D., Professor of Public Health, University of Minnesota

Dr. Bronstein's appearance is supported by a grant from Mead Johnson Laboratories.

Dr. Fraad's appearance is supported by a grant from Pet Milk Company.

Dr. Meyers' appearance is supported by a grant from Merck Sharp & Dohme.

INTERNAL MEDICINE

Wednesday, May 19

Louis XVI Room

Chairman: Roy J. Philipp, M.D., Carbondale

Secretary: Angelo P. Creticos, M.D., Chicago

3:00 P.M. "Primary Myocardial Disease"—

Panel

Moderator: John T. Sharp, M.D., Chief, Cardiopulmonary Laboratory, Hines V.A. Hospital; Associate Professor of Medicine, University of Illinois

Panelists: Vernon Sanders, M.D., Atlanta, Georgia

William R. Meadows, M.D., Assistant Chief, Cardiopulmonary Laboratory, Hines V.A. Hospital; Assistant Professor of Medicine, Loyola University

George Sutton, M.D., Assistant Director, Adult Cardiology, Cook County Hospital; Assistant Professor of Medicine, Northwestern University

SCIENTIFIC EXHIBITS

S-1

Title: GOVERNOR'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED.

Exhibitor: Louis A. Sabella

Institution: Governor's Committee on Employment of the Handicapped, Chicago.

Description: One of the most important economic and humanitarian projects in the state and nation is the achievement of equal employment opportunities of the handicapped. The physicians of Illinois constitute an integral part of this program. This exhibit shows the seven steps necessary to achieve this goal—hire because of ability; survey job requirements; determine aptitudes; analyze physical capabilities; place him correctly; break him in; and regular followup.

S-2

Title: COMBINED PSYCHOPHARMACOLOGICAL TREATMENT IN DEPRESSION.

Exhibitor: Veronica M. Pennington.

Institution: Veterans Administration Center, Jackson, Miss.

Description: The rationale of psychopharmacological agents in the neuroses and psychoses is discussed and justified. The biochemical cause of nervous and mental illness is delineated and examined. Charts presenting 1) Diagnostic category of patients in the research project, 2) Degree of improvement produced by psychotropic medication, 3) Effect on blood pressure and liver function, urine, and blood tests, 4) Dosage, 5) Side reactions. Four typical case histories are shown. Sum-

marization points up the bettered results with combined phrenotropic treatment as determined by this seven-year study.

S-3

Title: PNEUMOGYNECOGRAPHY.

Exhibitor: John P. Fotopoulos, Sheldon Berger and Frank W. Guthrie, Jr.

Institution: Evanston Hospital and Northwestern University Medical School, Chicago.

Description: The simple technique of pneumogynecography by introducing nitrous oxide intraperitoneally and making roentgenograms with the patient in the Trendelenberg position will be illustrated. The clinical material will include photographs, laboratory and clinical data of endocrine problems as well as illustrative roentgenograms of proven cases of Turner's syndrome, Stein-Levinthal syndrome and other intrapelvic diseases and masses.

S-4

Title: STUDIES IN INFANT FEEDING: INCIDENCE OF COLIC AND GASTROINTESTINAL DISTURBANCES.

Exhibitor: Lawrence Breslow and I. Robert Plotnick.

Institution: Lutheran General Hospital, Park Ridge.

Description: A previous study of infants on artificial formulas has revealed that disturbances of the gastrointestinal tract, especially colic, are frequently due to an inability to tolerate the fats or carbohydrate in these feedings. This is true especially after poor feeding technique, hunger and path-

ological entities are ruled out as etiological factors. A unique double-blind crossover in 127 infants, compared the acceptance of a standard evaporated milk and carbohydrate formula with a uniquely modified low casein and lower protein feeding. The formulas were alternated at 21-day intervals and reports were obtained at each alteration or more often on acceptability, regurgitation, frequency and characteristics of the stools, and the presence of any disturbing gastrointestinal symptoms. The study revealed that, although a majority of infants accepted both formulas equally well, the lower casein and lower protein formula was found to cause many fewer gastrointestinal disturbances.

S-5

Title: CANCER CHEMOTHERAPY BY INTRA-ARTERIAL INFUSION: A PILOT PROGRAM.

Exhibitor: A. Richard Grossman and Stuart J. F. Landa.

Institution: Cook County Hospital, Chicago.

Description: This exhibit describes the use of a chemotherapeutic agent by intra-arterial infusion in the treatment of 65 patients with squamous cell carcinoma of the head and neck. The rationale for this type of therapy is based upon interrupting the rapid growth of the cancer cells for prolonged periods of time. The drug, methotrexate, is infused by a special technique into the artery supplying the area of the cancer. Results have been gratifying. In 60 cases, the cancer regressed.

S-6

Title: DOES YOUR COUNTY HAVE A HEALTH DEPARTMENT?

Exhibitor: Harold K. Fuller

Institution: Illinois State-wide Public Health Committee, Springfield.

Description: A compact neon lighted exhibit illustrates the basic services of full-time county health departments and describes the possibility of cooperation between the County Medical Society and the county health department in providing adequate county health department services.

S-7

Title: ANTERIOR LUMBAR FUSION.

Exhibitor: A. C. Connors, J. A. Rooney, and J. P. Carroll.

Institution: Loyola University, Stritch School of Medicine, Chicago.

Description: This exhibit demonstrates through color illustrations and Kodachrome photographs the indications, technic, postoperative follow up and results in forty cases where this surgical procedure was performed.

S-8

Title: NEW TRENDS IN CONTRACEPTIVE CARE.

Exhibitor: Richard Frank and Frank Rubovits.

Institution: Planned Parenthood Association, Chicago.

Description: The exhibit depicts the progress made in Family Planning: (1) endorsement and support from national and local medical societies and public health organizations; (2) increasing acceptance of family planning by the public; (3) the efficacy and acceptance of oral contraception and (4) applicability of the new intra-uterine contraceptive devices in Family Planning.

S-9

Title: ACTIVITIES OF THE COMMISSION ON CONTINUING EDUCATION OF A.S.C.P.

Exhibitor: Thomas C. Laipply, Commissioner.

Institution: Commission on Continuing Education of the American Society of Clinical Pathologists

Description: The exhibit demonstrates programmed monographs in clinical pathology using the Teaching Machine. Included in the exhibit is a review of audio-visual seminars in all fields of clinical pathology. The teaching aids are available to all physicians, hospitals, and medical schools. A complete library of manuals dealing with special phases of laboratory work will be shown. The various film strips, monographs and machines will be displayed for visitors to view.

S-10

Title: SMALL INDUSTRY: AN OPPORTUNITY FOR THE FAMILY PHYSICIAN.

Exhibitor: Henry F. Howe and Lee N. Hames.

Institution: American Medical Association, Chicago.

Description: This exhibit attempts to acquaint the family physician with the different types of small plant health programs, and the part he can play in them. These programs range from very small operations in which the physician devotes only a small percentage of his time, to those in which he visits a plant on a frequent regular schedule. The exhibit tells how he can do a better job of caring for his working patient. Finally, the exhibit quotes the A.M.A. House of Delegates to the effect that organized medicine should exercise leadership in providing adequate health services for all employees.

S-11

Title: JUVENILE DELINQUENCY.

Exhibitor: C. E. Stepan, B. Block, R. T. Fielding, A. W. Fleming, J. B. Gillespie, R. E. Keeley and H. B. Okner.

Institution: Juvenile Delinquency Committee, Illinois State Chapter of the American Academy of Pediatrics, Chicago.

Description: This is an effort to acquaint the medical profession with the early causes and circumstances that predispose to delinquency; how to recognize them—how to help prevent them and of our personal responsibility as physicians to assist parents, teachers, social agencies, religious counsellors and society in general in its recognition and prevention.

S-12

Title: IMMUNOLOGIC RESISTANCE TO CARCINOMA PRODUCED BY ELECTROCOAGULATION; EXPERIMENTAL & CLINICAL OBSERVATIONS.

Exhibitor: Alfred A. Strauss, Max Appel, Otto Saphir & Adolph J. Rabinovitz.

Institution: Louis A. Weiss Memorial Hospital, Michael Reese Hospital and Franklin Boulevard Hospital, Chicago.

Description: The exhibit shows the 1st effects of electrocoagulation in 400 clinical cases of carcinoma of the rectum, viz., cell necrosis and absorption, disintegration of the carcinoma, and the progressive phases of complete disappearance of the carcinoma. It also shows the disappearance and histologic changes in spontaneous carcinoma of the breasts in white rats as well as the immunological factors and complete regression in rabbits by electrocoagulation in experiments on 513 rabbits.

S-13

Title: THE PHYSIOCHEMICAL RATIONALE FOR THE USE OF VASODILATORS IN HEMORRHAGIC SHOCK.

Exhibitor: William Schumer and Khushroo Patel.

Institution: The Chicago Medical School, Chicago.

Description: The exhibit reveals that with the use of vasodilators there is a decrease in the production of lactate, pyruvate and hydrogen ion concentration and, thereby, an increase in the survival rate in dogs. The cinemicrophotographs reveal an increased perfusion with vasodilators; a decreased perfusion with vasoconstrictors; and the mortality graphs show the protection that vasodilators produce in animals in severe low flow states. The vasodilators utilized were intravenous sodium nitrate and pentaerythritol tetranitrate. The exhibit is composed of three sections; Control, Vasoconstrictor, and Vasodilator. Each of the sections will contain three panels: The top panels will be cinemicrophotographs of controlled microcirculation; microcirculation under the influence of a vasoconstrictor; and microcirculation under the influence of a vasodilator. The middle panels will be composed of graphs showing the effect of pyruvate, lactate and hydrogen ion production by vasodilators, vasoconstrictors and the normal. The lower three panels will show the survival rate as related to the volume bled and treatment utilized.

S-14

Title: ROENTGEN MANIFESTATIONS OF NEUROFIBROMATOSIS.

Exhibitor: William T. Meszaros, Hildegard Schorsch and Francis Guzzo.

Institution: Cook County Hospital and Illinois Masonic Hospital, Chicago, Illinois.

Description: The roentgen manifestations of neurofibromatosis are varied and often bizarre. Knowledge of the X-ray findings is of value in the diagnosis of atypical cases. Some new X-ray manifestations are presented. Emphasis is placed on lesions of bone, chest and gastrointestinal tract.

S-15

Title: PRACTICAL PHOTOSCANNING.

Exhibitor: Noel F. Strasser, George Krawzoff, H. A. Lerner, and John H. Gilmore.

Institution: West Suburban Hospital, Oak Park.

Description: Photoscans of brain, thyroid, liver, pancreas and kidneys showing practicality of photoscanning in everyday practice are presented. The exhibit displays what the average isotope department can do for you and includes a continuous tape recording of questions and answers commonly asked. A handout is also included which gives the history and pathology of the scans presented.

S-16

Title: THE DIAGNOSIS AND MODIFIED SURGICAL TREATMENT OF POSTERIOR VAGINAL HERNIA (ENTEROCELE): (A Much Neglected, Misunderstood, and Mistreated Gynecologic Entity).

Exhibitor: Walter J. Reich, Mitchell J. Nechtow and Louis Keith.

Institution: Cook County Hospital, Chicago Medical School and Cook County Graduate School of Medicine, Chicago.

Description: The diagnosis and surgical management of herniation in the posterior vaginal sphere (enterocele) is still misunderstood and surgically mismanaged. The purpose of this exhibit is to demonstrate by illustrations and charts the etiology, pathology, symptoms, diagnosis, differential diagnosis and the surgical technique of the proper correction of these vaginal hernias. This exhibit will further demonstrate the details of surgical anatomy and pathology, and pitfalls to be avoided in the correction of the above entities.

S-17

Title: GERIATRIC INSOMNIA: A NEW LOOK.

Exhibitor: Jack Kleh, J. T. Hagenbucher and Charles W. Foulke.

Institution: The District of Columbia Village, Washington, D.C.

Description: This exhibit reports the results of a double-blind study of a barbiturate, pentobarbital, a non-barbiturate hypnotic, methypylon, and a placebo in the management of chronic insomnia in aged patients in an institutional setting. The 70 subjects represented a hardcore of insomniacs who had received a variety of bedtime sedation nightly for at least the year preceding the study. In recent years, in a continuing attempt to define the most suitable agents for this type patient, new drugs have been evaluated by substituting them for pentobarbital for nighttime sedation. Experience with methypylon suggested that it might have advantages over the pentobarbital and other hypnotics tested and the double-blind approach was used for more critical appraisal. Sleep response with methypylon was better than to pentobarbital in 17 of the 18 patients in whom a difference in effectiveness was noted.

S-18

Title: BLOOD CHEMISTRY EVALUATED FOLLOWING THE USE OF A DIURETIC-HYPOTENSIVE AGENT.

Exhibitor: Joseph J. Kozma.

Institution: Passavant Memorial Area Hospital, Jacksonville.

Description: Uric acid, potassium and glucose blood levels were determined after the administration of quinethazone, a quinazolinone compound related to but distinctly different from the thiazides. In some cases, uric acid levels were followed for as long as 14 to 16 months. They tended to be high when therapy was first instituted and leveled off after therapy progressed. Potassium and glucose levels were found to be within normal limits. Quinethazone was evaluated alone and in combination with reserpine or in some cases with potassium. Investigations of clinical efficacy and safety were also made.

S-19

Title: DOCTOR, YOU CAN HELP CONTROL CANCER.

Exhibitor: Caesar Portes, James D. Majarakis and Angelo P. Creticos.

Institution: Cancer Prevention Center, Chicago.

Description: This exhibit appeals to the practicing physician to help control cancer by examining his well patients in his office. It depicts the medical findings of the Center over the past five to six years in statistical form and outlines the entire examination procedure as practiced at the Center. Lastly, it appeals to the physicians to send their reports to the Center on patients examined there. Interesting transparencies of carcinoma are also shown.

S-20

Title: THE PROPER CARE OF LABORATORY ANIMALS.

Exhibitor: N. R. Brewer

Institution: Illinois Society for Medical Research, Chicago.

Description: The exhibit illustrates through colored transparencies and brief narrative, the proper care of laboratory animals used in research and teaching at a medical school. Constructive programs for the advancement of laboratory animal care are contrasted with regulatory proposals now before the U. S. Congress.

S-21

Title: DO YOU HAVE A PROBLEM IN TREATING RHEUMATIC DISEASES?

Exhibitor: Edward L. Tarpley, Nashville, Tenn.

Description: The purpose of this exhibit is to provide differentia data in the five main rheumatic diseases; rheumatoid arthritis, rheumatoid ankylosing spondylitis, osteoarthritis, osteoporosis and gout. Under each pathology we give distinctive information such as ratio of sexes, predominant ages, laboratory tests, clinical signs, x-rays, therapy and prognosis. It is the hope to review the types of treatment, both physical and drug, with the one idea in mind of helping the patient to improve or, if that is impossible, to re-

tard the disease progress as much as feasible. This exhibit may give some practicable ideas for some puzzling questions.

S-22

Title: SUSPECTED ADVERSE EFFECTS OF DRUGS.

Exhibitor: G. H. Berryman, R. P. Gwinn, H. D. Kautz, and A. L. Barlow.

Institution: Abbott Laboratories, North Chicago.

Description: Information to be presented in this exhibit is based upon actual experience gained in following up reports of suspected reactions or side effects of pharmaceutical products. It is intended to supplement a recently published report by the exhibitors which was published in the J.A.M.A. The exhibit will portray the roles of the pharmaceutical manufacturer and the clinician in the investigation of suspected adverse effects of drugs. Factors to be considered in such investigations also will be presented and oriented in relation to the suspected drug and the patient involved.

S-23

Title: PULMONARY DISEASE CAUSED BY PHOTOCHROMOGENIC MYCOBACTERIA.

Exhibitor: The Medical Staff.

Institution: The Suburban Cook County Tuberculosis Sanitarium District, Hinsdale.

Description: The exhibit will consist of chest films of representative cases showing results in (1) uncooperative patients, (2) cooperative patients treated with Chemotherapy only, and (3) patients treated with chemotherapy and surgery. Also included in the exhibit are color transparencies of the gross and microscopic pathology of this disease.

S-24

Title: THE AMERICAN CANCER SOCIETY.

Exhibitor: Aaron Spitzer.

Institution: American Cancer Society, Illinois Division, Chicago.

Description: Through charts and other illustrative material, the exhibit depicts the high

lung cancer death rate today and projected possible loss from the disease of more than one million present school children before they reach the age of 70. This prospect is of particular concern to the physician. This exhibit considers the role of the physician in the prevention of lung cancer and the efforts of the Society to this end.

S-25

Title: AMINOCAPROIC ACID: INVESTIGATIONS FROM A UNIVERSITY MEDICAL SCHOOL.

Exhibitor: C. Walton Lillehei, William Krivit, J. F. Perry, W. W. Spink, L. P. Sterns and Henry Gans.

Institution: University of Minnesota Medical School, Minneapolis, Minn.

Description: This exhibit describes the mode of action of a new hemostatic agent, aminocaproic acid. Several postulated modes of action are also discussed. Aminocaproic acid inhibits fibrinolysis and is clinically useful in the correlation of hyperfibrinolytic states, particularly that which accompanies open-heart surgery. A clinical study of the administration of aminocaproic acid to 240 patients undergoing open-heart surgery is presented.

S-26

Title: THE DRUG THERAPY OF HYPERTENSION: ITS MANAGEMENT AND COMPLICATIONS.

Exhibitor: Seymour Diamond, Edwin Feldman, and Irvin Belgrade.

Institution: The Samuel H. Flamm Foundation, Chicago.

Description: The medical treatment of hypertension is complicated by the many drugs now available to the physician. A classification of hypotensive drugs is presented. The varied collateral effects of these drugs are discussed. The occurrence of these collateral effects could limit efficacy. Iatrogenic disturbances may accompany effective response with antihypertensive drug therapy. Maximum benefit and minimal collateral effects can be obtained by combining hypotensive drugs. In combination smaller amounts of each agent are given and the efficacies are additive and the collateral effects min-

imized. Treatment of 100 hypertensive patients with combination therapy is discussed.

S-27

Title: CAUSES AND THERAPY OF EDEMA: EFFECT OF A NEW DIURETIC.

Exhibitor: Frederick Steigmann and Robert Griffin.

Institution: Hektoen Institute of Cook County Hospital, Chicago.

Description: The various causes of edema and their mechanisms will be presented with the aid of charts and posters. The indications for various types of diuretics will be discussed as well as some of the advantages and disadvantages of each type and the indications for the particular types of edema. The changes in the serum electrolytes and in the urinary electrolytes following the ingestion of various diuretics in various conditions will be presented and their influence on the choice of a diuretic for a particular type of edema will be discussed.

S-28

Title: THE USE OF AN ORAL ENZYME ACTIVATOR IN TRAUMA.

Exhibitors: G. Kenneth Lewis and A. Richard Grossman.

Institution: Department of Surgery, Cook County Hospital, Chicago.

Description: This exhibit describes a "double-blind" investigation in which an oral enzyme activator and a placebo were given to 100 patients. Fifty received the oral activator and 50 received the placebo in dosages of two tablets, four times daily, for six days. All patients were suffering from ordinary traumatic and surgical traumatic inflammatory conditions of the face, head and neck. Comparative results, shown photographically, reveal the enzyme activator an effective means for the alleviation of the distressing symptoms caused by trauma.

S-29

Title: MALIGNANT TUMORS COMPLICATING PREGNANCY.

Exhibitors: Frederick H. Falls and Charlotte S. Holt.

Institution: Illinois State Department of Public Health, Springfield.

Description: The more common malignant tumors of the uterus are sculptured (actual size) in various stages of development and correlated to illuminated translight films depicting their micropathology. Symptoms, diagnosis, pathology and treatment are briefly outlined in charts. The latter is discussed from the standpoint of the interest of both the mother and the fetus, and why the interests of the one should supercede that of the other, in a given case. Extragenital cancer, such as breast, lung, bowel and urological malignancy is presented as well as extrauterine genital cancer.

S-30

Title: COOPERATIVE BLOOD REPLACEMENT PLAN.
Exhibitor: Joseph D. Boggs, President.

Institution: Cooperative Blood Replacement Plan, Chicago.

Description: The exhibit describes the Replacement Plan which is designed to assist Chicagoland blood banks in meeting their public responsibility and to help the patient solve some of the problems created by the need for blood transfusions.

S-31

Title: PRESENT STATUS OF HEART VALVE SURGERY.
Exhibitors: Louis R. Head, James M. Head, Theodore R. Hudson and Jerome R. Head.
Institution: Chicago.
Description: Five years' experience in the management of over 100 cases of valvular heart disease is summarized. The role and limitation of valve replacement is analyzed.

TECHNICAL EXHIBITORS

Company	Booth	Company	Booth
Abbott Laboratories	T-52	The Medical Protective Co.	T-56
Americana Corporation	T-14	Medicard	T-10
Astra Pharmaceutical Products, Inc.	T-25	Merck Sharp & Dohme	T-57
Bacon, Whipple & Co.	T-54	The William S. Merrell Company	T-12
Berkeley Medical Instruments	T-49	Merrill Lynch, Fenner, Pierce & Smith	T-16
Beutlich, Inc.	T-11	Miller Pharmacal Company	T-20
Blue Shield Illinois Medical Service	T-47	Nehi-Royal Crown Corporation	T-45
Carnation Company	T-5	Northern Trust Bank	T-9
Ciba Pharmaceutical Company	T-59	Pacific Medical Equipment Company	T-23
The Coca-Cola Company	T-13	Parke, Davis & Co.	T-51
Contour Chairs Co.	T-62	Parker, Aleshire & Co.	T-44
Daniels Surgical & Medical Supplies	T-1, 2 and 3	Pfizer Laboratories	T-63
Edison Park Laboratories	T-36	Piper Aircraft Corporation	T-30
The Emko Company	T-35	Professional Life and Casualty	T-61
Encyclopaedia Britannica	T-46	PM Professional Management	T-40
Flint Laboratories	T-38	J. B. Roerig and Company	T-48
E. Fougera & Company, Inc.	T-28	Sandoz Pharmaceuticals	T-8
Geigy Pharmaceuticals	T-43	W. B. Saunders Company	T-41
Great Books with the Syntopicon	T-32	G. D. Searle & Co.	T-4
Hertz Rent-All	T-34	Sherman Laboratories	T-27
Investors Diversified Services, Inc.	T-6	SIG Incorporated	T-15
Johnson & Johnson	T-39	Smith Kline, & French Laboratories	T-7
7-Up Developers		Smith, Miller & Patch, Inc.	T-26
Association of Illinois	T-60	E. R. Squibb & Sons	T-42
Keeler Optical Products, Inc.	T-29	Swift & Company	T-22
Knoll Pharmaceutical Company	T-21	Thermo-Fax Sales, Inc.	T-37
Lederle Laboratories	T-24	The Upjohn Company	T-55
Eli Lilly and Company	T-58	Wallace Laboratories	T-31
Medical Business Consultants	T-53	Winthrop Laboratories	T-50
		X-Ray Identification Corporation	T-33

TECHNICAL EXHIBITORS

Booths T-1, T-2 and T-3

DANIELS SURGICAL AND MEDICAL SUPPLIES

DANIELS—with Mid-America's Most Ultra Modern Facilities to serve your Modern Professional Needs will again feature the newest in "TOP LINE BRAND" equipment and supplies.

See our individual Model Office Displays—also consult with our Planning, Decorating, Financing, and Service Department at our exhibit.

NEW ITEMS TO BE SHOWN—Introducing RITTER'S New #45 Examining Table—RITTER'S "75" UNIVERSAL Table with Full Range 12-Positions Automatic Flexibility. HAMILTON'S New Electrically-Operated Table—Hamilton Modular Furniture.—CLAY ADAMS Direct Reading Micro-Hematocrit—SIEMEN'S ULTRATHERM short-wave therapy apparatus with automatic tuning. VERTICAL OFFICE FILE ROLL-OUT Type (Card & Folder System). WELCH ALLYN Electrically illuminated diagnostic instruments and the Newest in DISPOSABLE PRODUCTS. Stop By and Receive a New Catalog on Physician's Items.

Booth T-4

G. D. SEARLE & CO.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Enovid for ovulation control and pregnancy and menstrual disturbances and Flagyl, a potent, new trichomonocidal agent for trichomonal vaginitis, cervicitis, urethritis and prostatitis.

Booth T-5

CARNATION COMPANY

Carnation Company cordially invites you to visit Booth #5, where its representatives will be pleased to welcome members and guests of the Illinois State Medical Society.

Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat and Carnalac New Formula are available.

Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Booth T-6

INVESTORS DIVERSIFIED SERVICES, INC.

Investors Diversified Services, Inc., with its subsidiary and affiliated companies, frequently referred to as the Investors Group, is unique among the nation's leading financial institutions. It is the largest investment corporation of its kind in the world . . . having currently more than \$4.5 billion

in assets under management, and in excess of one million customer accounts. From its beginning in 1894 the company has maintained its own sales organization for the purpose of offering its securities directly to the public.

Booth T-7

SMITH KLINE & FRENCH LABORATORIES

Representatives will be on hand to answer your specific questions and provide information on their products and services.

Booth T-8

SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth #8, where we are featuring Sansert, Mellaryl, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Booth T-11

BEUTLICH, INC.

BEUTLICH, INC. will feature PERIDIN-C as the non-hormonal control of the post menopausal hot flash, and to correct and prevent excessive bleeding in the non-pregnant women. CEO-TWO, the original, effective, non-irritating CO₂ generating evacuant suppository for the treatment and correction of constipation will be shown along with our new MANDALAY, a urinary antiseptic.

Booth T-12

THE WM. S. MERRELL COMPANY

Merrellmen always have an up-to-date status report on Merrell's significant prescription products. They will be happy to convey latest clinical reports to you in summary form when you visit the Merrell booth.

Booth T-13

THE COCA-COLA COMPANY

"Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Chicago, and the The Coca-Cola Company.

Booth T-14

AMERICANA CORPORATION

We invite you to visit Booth #14 and see our beautiful new edition of the Encyclopedia Americana and our innovation, the Min/Max Teaching Machine.

Booth T-15
SIG: INCORPORATED

U.R.I. CAPSULES . . . the "balanced" decongestant-antihistamine formula.

Study the impressive formula and view the distinctive capsule, and you will quickly realize why U.R.I. Capsules are effective and are well accepted by your patients.

RoCYTE Tablets, RoCYTE Injectable, OVLIN Tablets and OLVIN Injectable are other new formulations available for your viewing at the 1965 Illinois State Medical Convention. Mark Booth #15 on your program as an exhibit to visit!!!

Booth T-20
MILLER PHARMACAL COMPANY

Booth T-21
KNOLL PHARMACEUTICAL COMPANY

DILAUDID ampules, multiple dose vials and soluble tablets for prompt pain relief. DILAUDID COUGH SYRUP for persistent harassing cough. METRAZOL, NICO-METRAZOL, VITA-METRAZOL tablets and elixir for geriatric and convalescent patients. QUADRINAL and VEREQUAD tablets and suspension for relief of bronchospasm. AKINETON for organic and drug induced parkinsonism.

Booth T-22
SWIFT & COMPANY

A complete line of Swift's all-meat varieties—the economical form of meat protein for infant feeding—plus egg yolk products and High Meat Dinners—for your infant patients are exhibited at the Swift booth. Also featuring Jr. Franks and Chicken Sticks prepared especially for toddlers and young children. Copies of our NEW attractively illustrated, informative mother booklet are available.

Booth T-23
AUDIO-DIGEST FOUNDATION

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in seven series—General Practice, Surgery, Internal Medicine, Obstetrics & Gynecology, Anesthesiology and Ophthalmology.

Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Co.

Booth T-24
LEDERLE LABORATORIES

Lederle Laboratories, one of the leaders in medical research and development, is proud to support the 125th Annual Convention of the Illinois State Medical Society. Our sales representatives in Booth No. 24 are qualified to discuss products such as DECLOMYCIN, ACHROMYCIN V, ARIS-TOCORT, AMICAR, as well as our many services to physicians. We hope to be of service to your practice.

Booth T-25
ASTRA PHARMACEUTICAL PRODUCTS, INC.

Descriptive literature pertaining to preparations of XYLOCAINE® brand lidocaine Hydrochloride (ASTRA) for infiltration, regional nerve block, peridural, spinal, and topical anesthesia, XYLOCAINE Ointment, XYLOCAINE Jelly, XYLOCAINE Viscous, and XYLOCAINE Suppositories for topical application, as well as ASTRAFER® (dextriferron) and JECTOFR® (iron-sorbitol) for iron deficiency states, will be available at the ASTRA booth presided over by Norman W. Christiansen.

Booth T-26
SMITH, MILLER & PATCH, INC.

Smith, Miller & Patch, Inc. cordially invites you to visit their exhibit. Our representatives will be pleased to discuss the latest advances in therapy. Featured at our exhibit will be: Cephalgesic, a new product for the treatment of headache; Lipoflavonoid, Lipotriad, Vitron-C and Kondremul. Also featured will be a range of topical ophthalmic preparations including Vasocon-A, an antihistamine/decongestant.

Booth T-27
SHERMAN LABORATORIES

ELIXOPHYLLIN®

More air for your asthmatic patients—faster—with Elixophyllin. Sustained action: 24 hour bronchodilation with dosage q. 8 hr. Clinically proved by 30 published studies.

Severe attacks terminated in 15 to 30 minutes. Get a plastic bottle for your bag at our booth. Reprints are also available—sent to your office on request.

Booth T-28
E. FOUGERA & CO., INC.

We cordially invite all physicians attending to visit our exhibit in the main exhibit hall area for product information, physician service items, clinical trial material of products of interest in many areas of medicine. Informed representatives will be on hand to discuss with you therapeutic and diagnostic items of importance in internal medicine, cardiology, dermatology, obstetrics and gynecology and radiology.

Booth T-29**KEELER OPTICAL PRODUCTS, INC.**

KEELER OPTICAL PRODUCTS, INC. will exhibit the following: Ophthalmoscopes, Otosopes, Operating loupes, KOWA fundus Camera, Tonometers, Color Tests, Prism Bars, etc.

Booth T-30**TUFTS-EDGCUMBE, INC., PIPER DISTRIBUTOR**

Display Piper Aircraft literature and disseminate information regarding aircraft and flying.

Booth T-31**WALLACE LABORATORIES**

We invite you to visit our booth where our representatives in attendance will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice. Featured is our product 'Miltown' (meprobamate).

Booth T-32**GREAT BOOKS OF THE WESTERN WORLD**

The Great Ideas Program

A new advancement in liberal education, spanning 3,000 years of Western Thought from Homer and the Bible to the 20th century featuring the master key to the GREAT BOOKS—The Syntopicon.

The revolutionary Syntopicon, a totally new basic reference work, accomplishing in the field of ideas what the dictionary does for words and the encyclopaedia in the field of facts.

Booth T-33**X-RAY IDENTIFICATION CORPORATION**

NEW METHOD FOR IDENTIFYING X-RAY FILM....

X-Rite Radio Opaque Tape is a new product, which when written on with a stylus (ball point pen) or typed, can be affixed to a cassette and exposed with x-ray pictures for complete, professional, and legal x-ray identification.

Booth T-34**HERTZ RENT-ALL****Booth T-35****EMKO**

The EMKO Company exhibits the first aerosol foam contraceptive. EMKO has been professionally recommended for over four years, and highly accepted for a superior level of effectiveness and complete safety. Women appreciate its asthetic qualities—no mess, no odor, and no douching required. Stop at the EMKO Both #35 for samples.

Booth T-36**EDISON PARK LABORATORIES**

We sell physical therapy equipment which includes Pulsed High Frequency Diathermy, manufactured by Dynapower Systems of Santa Monica California and ultrasound, sine and galvanic manufactured by A.T.I. of Inglewood Calif.

Booth T-37**THERMO-FAX SALES INC.****Booth T-38****FLINT LABORATORIES**

SYNTHROID® (sodium levothyroxine) the pure thyroid hormone will be featured. A new injectable dosage will be introduced. Complete product information will be available.

Booth T-39**JOHNSON & JOHNSON**

The Johnson & Johnson exhibit will feature the latest improvements in surgical dressings and professional specialty products as developed by the Johnson & Johnson Research Laboratories. The most recent advances for the practice of medicine include SURGICEL Brand Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism; and DERMICEL Brand Surgical Tape, a newly-improved special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is an outstanding addition to a complete line of adhesive tape products. Well-informed representatives will be pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Booth T-40**PROFESSIONAL MANAGEMENT**

A complete business service for the medical profession. The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc. of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

Those in attendance at the Illinois State Medical Society Convention are cordially invited to stop at Booth No. 40 and meet the experienced PM Executives there.

Booth T-41**W. B. SAUNDERS COMPANY**

New Saunders books of special interest include: Current Therapy 1965; Gartland: Orthopaedics;

Edwards: Heart Disease; Hopkins: Leopold's Physical Diagnosis; Curran: The Doctor as a Witness; and a new edition of the Dorland: Illustrated Medical Dictionary.

Booth T-42

E. R. SQUIBB & SONS

"E. R. Squibb & Sons has long been a leader in development of new therapeutics agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At booth #42, we will be pleased to present up-to-date information on these advances for your consideration."

Booth T-43

GEIGY PHARMACEUTICALS

Geigy Pharmaceuticals cordially invites Members and Guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Booth T-44

PARKER, ALESHIRE & COMPANY

As the administrators of the officially sponsored Group Disability Plan for members of the Illinois State Medical Society, we invite you to consult with our representatives.

This approved Disability Plan offered to you as a member of your Society has paid well over ONE MILLION DOLLARS in benefits since it was established.

We suggest that you review your present income requirements in the event of total disability. Has your disability income program kept pace with today's cost of living? Please drop by our booth as one of our representatives will be glad to discuss this matter with you.

Booth T-45

NEHI ROYAL CROWN CORPORATION

The Nehi Royal Crown Corporation of Chicago, Illinois, franchised bottlers for Royal Crown Cola—one of the THREE leading colas in the country and the top selling Nehi fruit flavors and mixes cordially invite you to stop at the booth to taste America's number 1 low calorie drink—DIET RITE COLA—the drink that revolutionized the U.S. soft drink business.

Booth T-46

ENCYCLOPAEDIA BRITANNICA

"Encyclopaedia Britannica welcomes delegates to

The Illinois State Medical Society's 125th Annual Convention, and invites them to examine the great new edition of Britannica.

Official delegates may now purchase this magnificent set at an exhibit offer available only at our convention exhibits. Visit Britannica's Booth No. 46 for free descriptive literature."

Booth T-47

BLUE CROSS AND BLUE SHIELD

Booth T-48

J. B. ROERIG & COMPANY

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you.

Booth T-49

BERKELEY MEDICAL INSTRUMENTS

Accurate HEMOGLOBIN, serum CHOLESTEROL, true GLUCOSE, and URIC ACID determinations now can be done in minutes, in the doctor's office or in the laboratory. These new compact instruments, using simplified procedures, improve accuracy and provide "on the spot results." Procedures are so simplified and the instrument so reliably designed that even non-technical operators get results reproducible within 2 to 3%. Solid state construction and advanced component features assure reliable, completely reproducible performance.

Booth T-50

WINTHROP LABORATORIES

You are cordially invited to visit the Winthrop booth where representatives will be pleased to give you information on latest developments in the field of medicine.

Booth T-51

PARKE, DAVIS & COMPANY

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Booth T-52

ABBOTT LABORATORIES

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Booth T-53

MEDICAL BUSINESS CONSULTANTS, INC.

You may be surprised at the unusual savings

available to you. Savings in your time, taxes, and office costs are secured through analysis and recommendation on a monthly—or single occasion—basis. We'll be happy to explain how your colleagues are conserving more of their earnings through specialized management and tax planning.

Booth T-54
BACON, WHIPPLE & CO.

Bacon, Whipple & Co. welcomes your visit to our booth to inquire about investment securities. Our firm is a member of the New York Stock Exchange and other national exchanges, underwrites corporate bonds and stocks and tax-exempt bonds, and deals in over-the-counter securities. We offer our services as a broker and as a banker to corporations seeking new capital or financial advice.

We have available, without charge, reports on various securities and investment situations, as well as hourly reports on the course of the market. There will be a Dow-Jones news ticker for those interested in up-to-the minute bulletins. Our representatives will be glad to have your portfolio analyzed, without obligation, or supply information and current market prices of such securities as you may request.

Booth T-55
THE UPJOHN COMPANY

"Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments."

Booth T-56
THE MEDICAL PROTECTIVE COMPANY

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of 88,000 claims and suits during 66 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Booth T-57
MERCK SHARP & DOHME

The theme of the Merck Sharp & Dohme exhibit is "SERVICE TO MEDICINE". One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession and, also, lay films that can be utilized to

portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Booth T-58
ELI LILLY AND COMPANY

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products, and offer you precise information on recent therapeutic developments of Lilly research.

Booth T-59
CIBA PHARMACEUTICAL COMPANY

The exhibit will feature Esidrix® (hydrochlorothiazide CIBA). CIBA Representatives will discuss the benefits of this product in hypertension (alone and as concomitant therapy) and in various edematous states (congestive heart failure, toxemia of pregnancy, premenstrual edema, edema of pregnancy, steroid-induced edema, edema of obesity, nephrosis).

Booth T-60
7-UP DEVELOPERS ASSOCIATION OF ILLINOIS

The organizations that bottle and deliver sparkling, crystal-clear 7-Up and LIKE to the people of Illinois will be represented at Booth #60. They will be ready at all times to provide the fresh, clean taste of chilled 7-Up and LIKE for thirsty conventioners.

Booth T-61
PROFESSIONAL LIFE & CASUALTY COMPANY

Representatives of the Company will be in attendance during the entire meeting to discuss the plans of insurance available to members of the Medical Profession. Of particular interest is the Term Life Insurance Plan, currently receiving nationwide publicity. This Plan provides a fine addition to the professional man's insurance portfolio—allowing for a high amount of life insurance benefit at a nominal premium.

Booth T-62
CONTOUR CHAIRS CO.

Booth T-63
PFIZER LABORATORIES

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.

To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

SCIENTIFIC MOTION PICTURE PROGRAM

Monday, Tuesday, and Wednesday—May 17, 18, and 19

9:00 to 9:22

DIAGNOSIS AND TREATMENT OF RENAL HYPERTENSION.

Color, sound, 22 minutes.

Prepared by Chester C. Winter, M.D.

A complete resumé of renal hypertension is shown. This includes historical factors, important physical examination point, recommended diagnostic screening tests and further tests once a definite diagnosis has been made, a classification of lesions causing renal hypertension, treatment of various lesions caused by high blood pressure and a discussion of prognostic factors.

9:24 to 9:50

DEVELOPMENT OF THE IMMUNE CAPACITY IN THE NEWBORN.

Color, sound, 26 minutes.

This film shows the rate of decay material antibody in the newborn and the subsequent rate of productions of antibody in the infant. The origin of immunity in the newborn baby is presented by demonstrating how the antibodies pass from the mother through the placenta and how these passively transmitted small molecular globulins gradually disappear from the baby's circulation. By that time the infant begins to produce its own antibodies including those with larger molecules. This process is correlated with the role played by the thymus, with the appearance of plasma cells, and with the changes in lymphatic tissues. Experimental observations especially on the relation between developing immunity and reactions to skin transplantation in the newborn mouse are clearly presented.

9:52 to 10:08

LYMPHOGRAPHY IN FEMALE GENITAL CANCER.

Color, sound, 16 minutes.

Prepared by H. E. Averette, M.D., R. C. Hudson, M.D., H. I. Viamonte, M.D. and J. H. Ferguson, M.D., Miami, Florida.

Lymphography is the radiographic demonstration of lymph vessels and nodes following intralymphatic injection of radiopaque material. This technique is of value in preoperative study of the lymphatics in patients with genital malignancy. Obstruction to normal flow or marginal filling defects in nodes frequently indicates involvement of lymphatics by cancer. Coloration of the radiopaque material with green chlorophyll enables the surgeon to directly visualize lymphatics at the time of lymphadenectomy. This picture demonstrates the technique of lymphography and its value in the study and surgical treatment of a patient with vulvar carcinoma. A typical case is presented, the technique is shown and coloration of pelvic lymphatics is illustrated at the time of lymphadenectomy.

10:10 to 10:30

MODERN MANAGEMENT OF MULTIPLE BIRTHS.

Color, sound, 20 minutes.

Prepared by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division, American Cyanamid Company; Medical Consultants, William Alpern, M.D., and Allen Charles, M.D., of Chicago.

This new teaching film reviews the problems and emphasizes the special prenatal care needed to reduce morbidity and mortality in ALL multiple births—twins, triplets, quadruplets and quintuplets. Specific problems reviewed are prematurity, toxemia, anemia and stress—each of which poses a threat to fetal and maternal life if not recognized and managed early. The film reviews birth of identical quadruplets, showing how identity was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets, probably the only film record of such an event.

10:32 to 11:06

SURGERY OF ARTERIAL OCCLUSIVE DISEASE.

Color, sound, 34 minutes.

Prepared by Michael E. DeBakey, M.D., E. Stanley Crawford, M.D., Denton A. Cooley, M.D. and George C. Morris, Jr., M.D., of Houston, Texas. This film depicts the various patterns of atherosclerotic occlusive disease as seen clinically. Methods of diagnosis, including arteriography, are shown and corrective surgical techniques are demonstrated.

11:08 to 11:26

CINEGASTROSCOPY WITH THE FIBERSCOPE—AN AID TO DIAGNOSIS OF GASTRIC LESIONS.

Color, sound, 18 minutes.

Prepared by Henry Colcher, M.D., Charles A. Flood, M.D., Edmund N. Goodman, M.D., William B. Seaman, M.D. and Julius Wolf, M.D., N.Y.

This film presents the description of the method of obtaining color motion pictures through different gastroscopes with two systems of illumination and the demonstration of the procedure on the patient. Various diseases of the stomach, such as polyps, leiomyoma, various types of cancer, benign ulcer, various forms of gastritis, frozen stomach and gastrojejunostomy are illustrated. In addition to the gastroscopic findings, the motion picture includes the radiologic findings, and at times surgical specimens.

11:28 to 12:11

EMOTIONAL FACTORS IN GENERAL PRACTICE.

Black and white, sound, 43 minutes.

This film illustrates problems encountered by the general practitioner in helping the emotionally disturbed patient. With the permission of the

patient, films were made of actual interviews of the depressed patient being treated by a general practitioner. During the interviews, the nature of the patient's emotional problems became increasingly apparent to both her and the physicians, with the result that a dramatic improvement could be seen within two months of therapy.

Noon Break

2:00 to 3:00

OFFICE SURGERY.

Color, sound, 60 minutes.

Prepared by Samuel B. Kron, M.D., Philadelphia, Pennsylvania.

This film demonstrates many of the minor diagnostic and therapeutic surgical procedures that could be done in the office by general practitioners and industrial physicians. The opening scenes depict the steps preparatory to a typical case. Then follow a number of actual office procedures in the field of general surgery, orthopedics, proctology, gynecology and urology.

3:02 to 3:16

AMBULATORY HIP FUSION.

Color, sound, 14 minutes.

Prepared by Martin Altchek, M.D., Middletown, New York.

A new method of hip fusion, allowing immediate ambulation without casts or external fixation is demonstrated. The method is a central dislocation combined with iliac femoral intramedullary nailing. The operative technique on a cadaver and an actual operative procedure on a living person is demonstrated. A series of four cases are shown with the preimposed operative findings in each of the patients along with their x-ray pictures.

3:18 to 3:28

TRANSRECTAL NEEDLE BIOPSY.

Color, sound, 10 minutes.

Prepared by Raymond J. Jackman, M.D. and

Clyde E. Culp, M.D., Rochester, Minnesota.

Needle biopsy of the prostate and certain extrinsic masses by the transrectal approach has proved to be a safe procedure. The indications and complications are discussed in this film. The actual procedure is pictorialized in a step by step demonstration of the technique on the patient and by drawings.

3:30 to 4:03

DYNAMICS OF TUMOR EMBOLISM.

Color, sound, 33 minutes.

Prepared by Sumner Wood, Jr., M.D., Baltimore, Maryland.

This color motion picture film demonstrates: 1) the development and characteristics of the V2 carcinoma in Ascitic Fluid; 2) the new, inexpensive and simple rabbit ear chamber; 3) the microinjection techniques of studying tumor cell invasion with the Knisely quartz rod; 4) the intravascular behavior of carcinoma cells in blood vessels of the mesentery and ear chamber; and 5) the effects of fibrolytic enzymes (Streptokinase-activated or Urokinase-activated Plasminogen) on tumor cells and thrombi.

4:05 to 4:37

MEDIFILM REPORT VI—113th ANNUAL MEETING.

Black and white, sound, 32 minutes.

Presented are scientific exhibits, interviews with panelists and a film excerpt from the Annual AMA Meeting in San Francisco, June, 1964. Subjects of interest to both researchers and practitioners are included: Laser light, cardiac, telemetry, a simplified intestinal biopsy capsule, normal childbirth, mental retardation, hyperbaric oxygen, renal hemotransplantation, cancer chemotherapy (regional perfusion and ambulatory infusion) and intermittent peritoneal dialysis.

Calls Will Reach You Easily at '65 Convention

Doctor, please inform your staff that while you are attending the ISMS Convention you may be reached through the Physicians' Message Center. Here is the number to remember:

(312) 372-6258

This is a direct connection which does not go through the hotel switchboard.

MAY 16-19

SHERMAN HOUSE

DELEGATES' HANDBOOK

ILLINOIS STATE
MEDICAL SOCIETY

125TH
ANNUAL CONVENTION

SHERMAN HOUSE CHICAGO

MAY 16-19, 1965



<i>Delegates</i>	<i>Alternates</i>
Arthur T. Haebich	R. J. Haufe
T. J. Conley	Alfred Faber
George W. Holmes	Arnold U. Derman
Fred A. Tworoger	S. A. Franzblau
David O. Dale	Eugene T. Broccolo
Eugene M. Narsette	H. Paul Carstens
Alexander N. Ruggie	Allen Hrejsa

Jackson Park Branch

Wright Adams	Julius Ginsberg
Andrew J. Brislen	Chester Buy
William J. Hand	Henrietta Herbolzheimer
David S. Fox	Harry L. Hunter
Frank E. Maple	Daniel J. Pachman
Charles P. McCartney	

North Shore Branch

George H. Irwin	T. A. Davis
Burton Soboroff	Herschel Browns
C. A. Norberg	Joseph Skom
Chester L. Crean	Willis J. Diffenbaugh
Philip R. McGuire	Robert Jensik
Edward C. Helfers	Eugene J. Ranke
W. B. Stromberg, Sr.	John B. Murphy
Karl L. Vehe	Samuel T. Gerber
Joseph R. DeCaro	Frank M. Quinn
W. O. Ackley	David T. Petty
Philip M. Bedessem	Geo. C. Markoutsas

North Side Branch

Michael Boley	Coye C. Mason
Roland R. Cross	R. Gilchrist
Samuel L. Andelman	Samuel A. Levinson
William Hutchison	Bernard Peele
Anton Pantone	Marvin Rosner
Vincent Freda	Harold Lasky
Jack Williams	Benjamin Lounsbury
Erwin M. Patlak	Gustav Kaufmann
Clifton L. Reeder	Steven Barron
John Malia	Jas. P. FitzGibbons

North Suburban Branch

Robert A. Snyder	David R. Barnum
Harold C. Lueth	Howard C. Burkhead
C. Malcolm Rice, Jr.	James W. Ford
John L. Savage	Donald E. Hansen
William Harridge	William FitzPatrick
Arnold Wagner	Stanley E. Huff
William Cummings	Robert P. Cutler
Noel G. Shaw	Frank Pirruccello
Raymond H. Conley	Jerome T. Paul

Northwest Branch

N. J. Kupferberg	Louis A. Wajay
M. J. Kutza	M. A. Rydelski
A. J. Linowiecki	*James M. McDonnough
F. M. Nicholson	L. S. Sluzynski
Peter N. Furno	R. V. Kochanski
S. M. Goldberger	Alfred A. Zanette
	*deceased

<i>Delegates</i>	<i>Alternates</i>
------------------	-------------------

South Chicago Branch

Tibor Czeisler	Morris Friedell
M. E. Finsky	John M. Coleman
Simon J. Saltman	John J. Marlow
Arthur W. Fleming	Albert L. Pisani

South Side Branch

Quentin Young	Jacob Epstein
Robert R. Mustell	Maurice Gleason

Southern Cook County Branch

Cyril Gallati	Gerard Gnade
Frederick Weiss	John Koenig
Howard W. Schneider	Leonard Lewis

Stock Yards Branch

Glenn A. Burckart	Frank J. Nowak
E. J. Lukaszewski	Joseph M. Ruda

West Side Branch

George Kaiser	Eugene T. Hoban
Anna Marcus	George Rezek
Joseph F. O'Malley	Louis S. Varzino

At-Large

Theo. R. VanDellen	A. L. Burdick, Sr.
Casper Epsteen	Harold A. Sofield

DOWNSTATE DELEGATES AND ALTERNATES

<i>County Delegate</i>	<i>Alternate</i>
ADAMS	
Richard Cooper	Harold Swanberg
ALEXANDER	
James L. Crouse	
BOND	
Boyd E. McCracken	Max Fraekel
BOONE	
John H. Steinkamp	M. Paul Dommers
BUREAU	
K. M. Nelson	G. E. Giffin
CARROLL	
E. C. Turner	L. B. Hussey
CASS-BROWN	
B. A. DeSulis	James J. Hea
CHAMPAIGN	
Carl Greenstein	H. J. Kolb
C. H. Walton	R. E. Schaede

<i>County Delegate</i>	<i>Alternate</i>	<i>County Delegate</i>	<i>Alternate</i>
CHRISTIAN		IROQUOIS	
C. D. Brummitt	Ralph M. Seaton	R. Kent Swedlund	James Dailey
CLARK		JACKSON	
Eugene P. Johnson	Geo. T. Mitchell	J. A. Petrazio	Martin H. Powell, Jr.
CLAY		JASPER	
Wm. T. Kamp	H. T. Fehrenbacker	Don L. Hartrich	C. O. Absher
CLINTON		JEFFERSON-HAMILTON	
M. A. Bateman	J. Roger Sosa	Herman Rogers	A. W. Anderson
COLES-CUMBERLAND		JERSEY	
Joseph R. Mallory	Mack W. Hollowell	Bernard Baalman	H. E. Wuestenfeld
CRAWFORD		JO DAVIESS	
Charles N. Salesman	Raymond B. Murphy	J. Eric Gustafson	A. L. Hildinger
DEKALB		JOHNSON	
T. P. deGraffenried	J. W. Ovitz, Jr.	E. A. Veach	W. J. Wakefield
DEWITT		KANE	
Herman L. Meltzer	Charles A. Ramey	John A. Newkirk	D. M. Schleifer
DOUGLAS		Wayne N. Leimbach	William H. Donovan
E. J. Gross	Myron Boylson	B. F. Shirer	J. L. Bordenave
DUPAGE		KANKAKEE	
James P. Campbell	Frederick C. Kuharich	Donald A. Meier	Dale M. Learned
Morgan M. Meyer	Arthur P. LeBeau	KENDALL	
Joseph R. O'Donnell	Chas. B. VanGorder	Michael R. Saxon	Ray Crawford
J. P. Schweitzer	B. L. Rodkinson		
EDGAR		KNOX	
Jerry M. Ingalls	James H. Acklin	J. A. Bowman	Fred Stansburg
EDWARDS		LAKE	
Charles P. Salisbury	Andrew Krajec	George B. Callahan	Charles Culmer
EFFINGHAM		Donald Nellins	Walter J. Reedy
Wm. S. Vanbergen	James R. Gartner	Earl V. Klaren	M. J. McAndrew
FAYETTE		LASALLE	
Stanley W. Moore	Hans Rollinger	William A. Scanlon	J. B. Aplington
FORD		LAWRENCE	
Paul W. Sunderland	Ross N. Hutchison	Tom Kirkwood	R. T. Kirkwood
FRANKLIN		LEE	
John P. Pope	Harry L. Lewis	Wm. A. McNichols	Charles H. LeSage
FULTON		LIVINGSTON	
Keith H. Frankhauser	P. D. Reinertsen	Don E. Ervin	George T. Crout
GALLATIN		LOGAN	
John E. Doyle	W. F. Stanelle	Charles R. Bardwell	Glen Tomlinson
GREENE		MCDONOUGH	
Paul A. Dailey	A. K. Baldwin	V. B. Adams	Donald Dexter
HANCOCK		MCHENRY	
C. W. Bruehsel	Byron I. Mueller	M. Mijanovich	A. Mijanovich
HENDERSON		MCLEAN	
Silvino Lindo	Elmer Swann	A. Edward Livingston	
HENRY		MACON	
Paul M. Schmidt	William D. Larson	Maurice D. Murfin	Hyman J. Burstein
		C. Elliott Bell	C. F. Downing

<i>County Delegate</i>	<i>Alternate</i>
MACOUPIN Joseph J. Grandone	Roger Quinn
MADISON Eugene F. Moore Edward K. DuVivier	Julius Katz J. Mather Pfeiffenberger
MARION Karl D. Venters	Karl Venters
MASON J. W. McHarry	H. W. Maxfield
MASSAC George Green	Virgil O. Decker
MENARD Robert J. Schafer	Stanley Paulauskis
MERCER M. E. Conway	John E. Bohan
MONROE Otto L. Kremer	Russell W. Jost
MONTGOMERY George A. Telfer	James D. Telfer
MORGAN Albert F. Fricke	E. C. Bone
MOULTRIE Eugene J. Boros	
OGLE Russel W. Zack	Arthur R. Bogue
PEORIA Wm. O. McQuiston Norman Powers F. A. Christensen	Wm. F. Chambers S. M. Scalzo George J. Best
PERRY C. E. Cawvey	James B. Stotlar
PIATT Edgar W. Weir	W. E. Mundt
PIKE-CALHOUN James H. Rutledge	James E. Goodman
PULASKI James G. Conger	A. L. Robinson
RANDOLPH Rob't. E. Schettler	O. W. Pfasterer
RICHLAND Wm. A. Moore	Wayne Moulton
ROCK ISLAND J. G. Gustafson Theodore Grevas	H. T. Kutsunis Raymond W. Dasso
ST. CLAIR Wm. H. Walton V. P. Siegel	Lloyd F. Walk Harold McCann
SALINE N. A. Thompson	D. A. Lehman

<i>County Delegate</i>	<i>Alternate</i>
SANGAMON Preston V. Dilts Chauncey C. Maher, Jr. A. R. Eveloff	Ross Schlich Richard F. Herndon
SCHUYLER Henry C. Zingher	
SHELBY Duncan Biddlecombe	H. H. Pettry
STEPHENSON Thomas A. Haymond	H. R. Osheroff
TAZEWELL Roger Neumann	Robert L. Tucker
UNION William H. Whiting	John Pfau
VERMILION G. L. Seitzinger	Edwin G. Andracki
WABASH William L. Walling	Don Risley
WARREN Kenneth E. Ambrose	Russell M. Jensen
WASHINGTON Walter P. Plassman	William P. Lesko
WAYNE C. J. Jannings	E. S. Talaga
WHITE S. B. Abelson	D. R. Hansard
WHITESIDE C. J. Mueller	Isaac Vande'myde
WILL-GRUNDY Lloyd Jessen Leonard F. Roblee	George Woodruff Robert J. Becker
WILLIAMSON James A. Felts	Richard Fox
WINNEBAGO Paul A. VanPernis Harold E. Zenisek F. A. Munsey	L. P. Johnson A. R. K. Matthews Harry E. LaPlante
WOODFORD Robert Lykkebak	Joseph C. Phifer

AGENDA FOR 1965 MEETING OF THE HOUSE OF DELEGATES

**First Session: Sunday Afternoon
May 16, 1965
3:00 p.m.**

1. Call to order by the Speaker of the House—
Edward W. Cannady
2. Invocation—Joseph R. Mallory, *Chairman*,
Committee on Religion and Medicine
3. Roll call

- Report of the Committee on Credentials—Francis W. Young, Morgan M. Meyer, *Co-Chairmen*
4. Report of the Committee on Rules and Order of Business—C. J. Jannings, *Chairman*
 5. Approval of the minutes of the May, 1964 meeting of the House of Delegates
Approval of the minutes of the called meeting of the House of Delegates,
February 7, 1965
 6. Remarks of the Speaker—Edward W. Cannady
 7. Memorial Service—Presentation of the list of ISMS members who have died since May, 1964—Jacob E. Reisch, *Secretary*
 8. Introduction of representatives of the Student American Medical Association
Chicago Medical School
Northwestern University Medical School
Stritch School of Medicine of Loyola University
University of Chicago School of Medicine
University of Illinois College of Medicine
 9. Remarks—President, Illinois Chapter, Medical Assistants Association, Mrs. Shirley Kleinschmidt, *Eligin*
 10. Introduction of representatives of other state medical societies and honored guests
Edward A. Piszczek, *President*
 11. Presentation of AMA-ERF checks to representative of the five medical schools in Illinois—H. Stanley Bennett, *Dean*, University of Chicago School of Medicine, by Carl E. Clark, *Chairman*, Finance Committee of the Board of Trustees, ISMS
 12. President's Address—Edward A. Piszczek, Chicago
 13. Special report of the President of the Woman's Auxiliary—Mrs. Willard C. Scrivner, East St. Louis
 14. Special report of the Executive Administrator—Robert L. Richards
 15. Announcement of reference committees for the 1965 House of Delegates
 16. Consideration of annual reports and presentation of supplementary reports of the Board of Trustees—William E. Adams, *Chairman*
 17. Unfinished business
 18. New business
 - a. Introduction of resolutions and referral to reference committees.
 - b. Other new business
 19. Recess.

Second Session: Tuesday Afternoon
May 18, 1965
3:30 p.m.

1. Call to order by the Speaker of the House—Edward W. Cannady
2. Roll call
Report of the Committee on Credentials
3. Report of the Committee on Rules and Order of Business
4. Selection of the meeting place for 1968 annual meeting

5. Reports of reference committees:
 - a. Administrative Services, Keith H. Frankhauser, *Chairman*
 - b. Constitution and Bylaws, Charles J. Weigel, *Chairman*
 - c. Legislation and Public Affairs, L. F. Mammoser, *Chairman*
 - d. Economics and Insurance, Clifton L. Reeder, *Chairman*
 - e. Publications and Scientific Services, C. H. Walton, *Chairman*
 - f. Public Relations, Chauncey C. Maher, Jr., *Chairman*
 - g. Miscellaneous Business, Robert A. Snyder, *Chairman*
6. Unfinished business
7. New business
 - a. Communications
 - b. Election of Emeritus Members—Presentation by Jacob E. Reisch, *Secretary*
 - c. Election of Retired Members—Presentation by Jacob E. Reisch, *Secretary*
 - d. Other new business
8. Recess

Third Session: Wednesday Afternoon
May 19, 1965
2:00 p.m.

1. Presentation of the CAMP LECTURE
Introduction by Edward A. Piszczek, *President*
2. Call to order by the Speaker of the House—Edward W. Cannady
3. Induction of the President Elect—Burtis E. Montgomery of Harrisburg—into the office of President of the Illinois State Medical Society by the retiring President, Edward A. Piszczek, Chicago
4. Roll call
Report of the Committee on Credentials
5. Report of the Committee on Rules and Order of Business
6. Announcement of awards to Scientific Exhibitors—Coye C. Mason, *Director and Chairman of Committee on Scientific Exhibits*
7. Election of Officers:

a. President	(CMS)
b. First Vice President	(downstate)
c. Second Vice President	(CMS)
d. Secretary-Treasurer	(downstate)
e. Speaker of the House	(downstate)
f. Vice Speaker of the House	(CMS)
8. Election of Trustees:

<i>District</i>	<i>Term expiring:</i>
First	Carl E. Clark, Sycamore
Second	Ralph N. Redmond, Sterling
Third	Caesar Portes, Chicago
	Frank J. Jirka, River Forest
Eleventh	Bernard Klein, Joliet
9. Election of Delegates to the American Medical Association
(To take office January 1, 1966 and serve for a term of two years)

Terms expiring:

H. Kenneth Scatliff
Walter C. Bornemeier
Frank H. Fowler
Arthur F. Goodyear
Harlan English
Edward W. Cannady

10. Election of Alternate Delegates to the American Medical Association
(To take office January 1, 1966 and serve for a term of two years)

Terms expiring:

George F. Lull (alternate for Scatliff)
George C. Turner (alternate for Bornemeier)
Edward A. Piszczek (alternate for Fowler)
Newton DuPuy (alternate for Goodyear)
Jacob E. Reisch (alternate for English)
Carl E. Clark (alternate for Cannady)

11. Election of Standing Committees

- a. Committee on Disaster Medical Care

Term expiring:

Jack Baldwin, Springfield
(Three year term)

- b. Grievance Committee

Term expiring:

J. E. Wheeler, Belleville (Three year term)

- c. Laboratory Evaluation

Term expiring:

Theodore Z. Polley, Joliet
(Three year term)

- d. Committee on Medical Education

Term expiring:

Herschel L. Browns, Chicago
(Three year term)

- e. Committee on Occupational Health

Term expiring:

Chester R. Zeiss, Chicago
(Three year term)

- f. Prepayment Plans and Organizations

Term expiring:

E. Lee Strohl, Chicago (Three year term)

- g. Committee on Public Safety

Term expiring:

Walter Plassman, Ashley
(Three year term)

12. The fixing of per capita assessment for membership for 1966

13. Any additional reference committee reports not presented at the second session of the House held on Tuesday, May 18

14. Unfinished business

15. New business

(The induction of the President Elect will probably take place immediately following the Camp Lecture in order that more people may be present at this ceremony. If such is the ruling, the Committee on Rules and Order of Business will so recommend.)

16. Adjournment, sine die.

COMMITTEES FOR 1965 HOUSE OF DELEGATES

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof. The committee shall pass out and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

It shall meet at least one hour prior to the time scheduled for the opening of each session of the House. The committee will meet:

Sunday, May 16	2:00 p.m.
Tuesday, May 18	2:00 p.m.
Wednesday, May 19	1:00 p.m.

Francis W. Young,
Co-Chairman Englewood Branch CMS

Morgan M. Meyer,
Co-Chairman DuPage County

J. A. Petrazio Jackson County

Jerry M. Ingalls Edgar County

Glenn A. Burckart Stock Yards Branch CMS

C. A. Norberg North Shore Branch CMS

COMMITTEES ON RULES AND ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods of procedure

and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker of the House of Delegates.

The committee shall contact the Speaker prior to each session of the House to make sure that all recommendations for House action are included in its report.

C. J. Jannings,

Chairman

Russell W. Jost	Wayne County
Thomas A. Haymond	Monroe County
Raymond H. Conley	Stephenson County
M. J. Kutza	North Suburban CMS
Stanley Ruzick	Northwest Branch CMS
	Calumet Branch CMS

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever the situation arises which requires a ballot vote or executive session.

Charles R. Bardwell,

Chairman

James H. Rutledge	Logan County
George Green	Pike County
Tibor Czeisler	Massac County
Michael Boley	South Chicago CMS
Anna Marcus	North Side Branch CMS
	West Side Branch CMS

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Meeting: 7:30 p.m.
Sunday, May 16, Life Room #108

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

Charles J. Weigel, <i>Chairman</i>	Aux Plaines Branch	CMS
Vincent Freda	North Side Branch	CMS
Edward J. Krol	Englewood Branch	CMS
G. L. Seitzinger	Vermilion County	
Theodore Grevas	Rock Island	
Albert F. Fricke	Morgan County	

REFERENCE COMMITTEE ON ADMINISTRATIVE SERVICES

Meeting: 7:30 p.m.
Sunday, May 16, Old Chicago Room #101

This committee shall consider and submit its recommendations to the House of Delegates on the following reports:

- The President
- The President-Elect
- The Vice Presidents
- The Secretary-Treasurer (including the annual audit and the budget under which the ISMS is operating)
- Trustees of the 11 Trustee Districts
- The Trustee at Large
- The Chairman of the Board, including the reports of:
 - Ad Hoc Committee to Study the Policy of the Chamber of Commerce of the United States
 - Director—Department of Public Health
 - Director—Department of Mental Health
 - Policy Committee
- The Speaker of the House of Delegates
- The Vice Speaker of the House
- The Executive Administrator

Keith H. Frankhauser, <i>Chairman</i>	Fulton County	
Maurice D. Murfin	Macon County	
Richard Cooper	Adams County	
Noel G. Shaw	North Suburban	CMS
Clair M. Carey	Aux Plaines Branch	CMS
Chas. P. McCartney	Jackson Park Branch	CMS

REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC AFFAIRS

Meeting: 7:30 p.m.
Sunday, May 16, French Room #107

This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

- Archives—Emmet F. Pearson, *Chairman*
- Benevolence—Keith H. Frankhauser, *Chairman*
- Illinois Dept., Registration & Education—Jacob E. Reisch, *Chairman*
- Impartial Medical Testimony—Clinton L. Compere, *Chairman*
- Laboratory Evaluation—James B. Hartney, *Chairman*
- Legislation—V. P. Siegel, *Chairman*
- Medical Legal—Luis V. Amador, *Chairman*
- Narcotics & Hazardous Substances—Ross Schlich, *Chairman*
- Occupational Health—Edward C. Holmblad, *Chairman*
- Public Affairs—John A. Newkirk, *Chairman*

L. F. Mammoser, <i>Chairman</i>	Irving Park Branch	CMS
Howard W. Schneider	Southern Cook County	CMS
Coleman J. O'Neill	Douglas Park Branch	CMS
William H. Walton	St. Clair County	
John H. Steinkamp	Boone County	
N. A. Thompson	Saline County	

REFERENCE COMMITTEE ON ECONOMICS AND INSURANCE

Meeting: 7:30 p.m.
Sunday, May 16, Orchid Room #106

This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

- Aging—Edward W. Cannady, *Chairman*
- Blue Cross-Blue Shield, Liaison to—Norris L. Brookens, *Chairman*
- Drug Manual—James A. Weatherly, *Chairman*
- Fee Schedules—George F. Lull, *Chairman*
- Hospital Relations—Noel G. Shaw, *Chairman*
- Illinois Department of Public Aid, Advisory Committee to—Fred A. Tworoger, *Chairman*
- Medical Economics—Norris L. Brookens, *Chairman*
- Prepayment Plans and Organizations—Maurice M. Hoeltgen, *Chairman*
- Rehabilitation Services—Edward L. Compere, *Chairman*
- Relative Value—C. Elliott Bell, *Chairman*

Clifton L. Reeder, <i>Chairman</i>	North Side Branch	CMS
Arthur W. Fleming	South Chicago Branch	CMS
Edward A. Razim	Douglas Park Branch	CMS
Paul M. Sunderland	Ford County	
A. Edward Livingston	McLean County	
Paul A. VanPernis	Winnebago County	

REFERENCE COMMITTEE ON SCIENTIFIC SERVICES & PUBLICATIONS

Meeting: 7:30 p.m.

Sunday, May 16, Holiday Room #105

This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

Convention Committees:

Scientific Assembly—William M. Lees, *Chairman*

Scientific Exhibits—Coye C. Mason, *Chairman*

To Study Annual Convention—George F. Lull, *Chairman*

Cancer—Augusta Webster, *Chairman*

Cardiovascular Disease—Oglesby Paul, *Chairman*

Child Health—Ralph Kunstadter, *Chairman*

Continuing Education—Robert J. Freeark, *Chairman*

Environmental Health—Edward Press, *Chairman*

Eye Health—Frank W. Newell, *Chairman*

Maternal Welfare—Robert R. Hartman, *Chairman*

Medical Education (AMA-ERF) Daniel Ruge, *Chairman*

Mental Health—Donald Oken, *Chairman*

Nursing—W. I. Taylor, *Chairman*

Nutrition—Paul A. Dailey, *Chairman*

Perinatal Mortality—Leo G. Perucca, *Chairman*

Radiation—Howard C. Burkhead, *Chairman*

Tuberculosis—Charles K. Petter, *Chairman*

Vital Certificates—H. Close Hesseltine, *Chairman*

Illinois Medical Journal

The Editor—T. R. Van Dellen

The Editorial Board—Samuel A. Levinson, *Chairman*

The Journal Committee—Jacob E. Reisch, *Chairman*

The Educational and Scientific Foundation—Harlan English, *Chairman*

C. H. Walton, <i>Chairman</i>	Champaign County
Lloyd Jessen	Will-Grundy County
Boyd McCracken	Bond County
David S. Fox	Jackson Park
	Branch CMS
George H. Irwin	North Shore Branch CMS
Harold C. Lueth	North Suburban CMS

REFERENCE COMMITTEE ON PUBLIC RELATIONS

Meeting: 7:30 p.m.

Sunday, May 16, Time Room #110

This committee shall consider and submit its recommendations to the House of Delegates on the reports of:

Disaster Medical Care—Max Klinghoffer, *Chairman*

Ethical Relations—Charles Allison, *Chairman*
Fifty Year Club—Morris Fishbein, *Chairman*
Grievance Committee—Arkell M. Vaughn, *Chairman*

Illinois Medical Assistants Association, Advisory to—Maynard Shapiro, *Chairman*

Public Relations—Leo P. A. Sweeney, *Chairman*

Public Safety—Julius M. Kowalski, *Chairman*

Religion and Medicine—Joseph R. Mallory, *Chairman*

Rural Health & Student Loan Fund—Jack Gibbs, *Chairman*

Student AMA Chapters, Advisory to—Hilger Perry Jenkins, *Chairman*

Chauncey C. Maher, Jr.

Chairman

Michael R. Saxon

Earl V. Klaren

Chester L. Crean

N.J. Kupferberg

Wright Adams

Sangamon County

Kendall County

Lake County

North Shore Branch CMS

Northwest Branch CMS

Jackson Park

Branch

CMS

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Meeting: 7:30 p.m.

Sunday, May 16, Gold Coast Room #111

This committee shall consider all business not allocated to any of the enumerated committees, and any new business to come before the House of Delegates for which no other provisions have been made. Assignments will be made to this committee by the Speaker of the House.

This committee shall consider and submit its recommendations to the House of Delegates on the following reports:

Illinois Association of Professions—George B. Callahan, *Chairman*

Liaison to the Illinois Pharmaceutical Association—George B. Callahan, *Chairman*

Quackery—Frank H. Fowler, *Chairman*

Osteopathic Association, Liaison Committee to—Walter C. Bornemeier, *Chairman*

Membership—H. Close Hesseltine, *Chairman*

ISMS Delegation to the AMA House of Delegates—Edward W. Cannady, *Chairman*

Committee to Study Committees—Caesar Portes, *Chairman*

Policy—Newton DuPuy, *Chairman*

Robert A. Snyder, *Chairman*

North Suburban
Branch

CMS

Quentin Young

South Side Branch CMS

Alexander N. Ruggie

Irving Park Branch CMS

Herman Rogers

Jefferson-Hamilton County

William O. McQuiston

Peoria County

B. F. Shirer

Kane County

ANNUAL REPORTS



OFFICERS AND TRUSTEES

REPORT OF THE PRESIDENT OC-1

At no time in American medical history have the problems facing organized medicine been greater. Political forces in the United States, which have been working for several decades to socialize the American system of medicine, have been gaining greater and greater support from many sources. As I approach the last months of my year as President, a showdown looms as to whether the American system of the free practice of medicine, which has produced the greatest medical progress in the world, shall survive or whether Americans shall become Social Security numbers as far as their individual health service needs are concerned.

In reading this morning's paper, Feb. 26, 1965, I find such abstracts as the following:

"Dr. J. L. Keeley, personal physician of Cardinal Meyer, reports that: 'The Cardinal's general condition remains stable, and his responses are the same as they have been over the last 24 hours.'"

Another quote on the same front page reads: "Dr. Joseph Bailey, personal physician of Senator Dirksen, reports that the condition of the Senator remains unchanged."

In the same paper another statement: "Dr. J. T.

Byran, personal physician of James M. Hadden, Hadden's Mfg. Co. of Chicago, reports that death apparently was due to acute coronary occlusion."

These examples of a leading Catholic clergyman, an outstanding political statesman, and an individual business man indicate that they all had a personal physician looking after their health. This verifies the freedom of choice which American Medicine has offered. The future years may not permit this selection of personal physician. It is for this freedom, for these high standards of medical care, and for the local administration of health matters, that the medical profession continues to fight.

I have enjoyed, during my year as President, the opportunity and the responsibility of meeting not only with groups of organized physicians but groups of organized citizens, believing in this freedom as a part of the American heritage. Their interest and their stimulation have gone far to encourage medical leaders to continue their fight for these principles.

Administrative Staff

The Illinois State Medical Society has been extremely fortunate in having re-organized the admin-

istrative staff during my tenure as Chairman of the Board of Trustees in 1960-62. When the time came to present the issues of private enterprise versus government medicine, the medical society staff was ready to give to the citizens of Illinois a very clear and definite understanding of the problems confronting our population.

The administrative staff, under excellent leadership, aided not only the state society officers and Board of Trustees, but also the officers and members of county medical societies and the woman's auxiliaries, providing the information necessary to carry this campaign to the citizens of the state of Illinois. Our interest in good government as well as in good health protection for the people was received with enthusiasm by organized groups.

The Illinois State Medical Society and its county branches led all the states in the union in visits to their congressmen and to the public affairs conferences of the United States Chamber of Commerce in Washington, D. C. When the American Medical Association program for the adoption of Eldercare was ready, Illinois immediately began its radio, newspaper, and television campaign for the support of the Eldercare bill in the Federal Congress. The impact of Illinois medicine on the work of the United States Chamber of Commerce has been well demonstrated by the fact that 65 of our county medical societies are members not only of their local and state chambers of commerce but also are members of the United States Chamber of Commerce.

Medical Progress in Illinois

The first responsibility of the medical profession is to provide the citizens of Illinois with the best medical care science has to offer. This has been well established by not only administrative interest and efforts but by cooperation with other professional agencies to meet the health problems in the state.

Almost every hospital in Illinois is approved by the Joint Commission on the Accreditation of Hospitals. This cooperative effort of the state medical society and the Illinois Hospital Association has received national recognition. Very shortly all our hospitals will have Joint Commission approval.

The physicians working with the Illinois Department of Public Health to bring our residents the best public health programs have continued their cooperation. Although the staff of the Illinois Department of Public Health is limited, its personnel consistently has remained high in qualifications, service, and cooperation with all state agencies.

The physicians' interest in modern trends and treatment of mental health problems has brought to Illinois mental health leadership, stimulated by Gov. Otto Kerner. By putting into effect all the modern knowledge in the treatment of mental illness, as early and effectively as possible, Illinois has found the establishment of zone areas most effective.

The cooperation between physicians and the Illinois Department of Public Aid, which has been extremely close for several decades, was further strengthened by the extension of the Kerr-Mills Act in Illinois to provide care, more adequately, for the needy aged.

Illinois has maintained an exceptionally good record in the field of control of communicable diseases. This record could not have been achieved without the wholehearted cooperation of medicine, the Illinois Department of Public Health, state institutions, and all other state agencies.

Medical Registration

The state of Illinois with its five medical schools produced fewer physicians than it did 10 years ago. There is need to take a very good look at the prospects for the establishment in the state of one or two additional medical schools to meet the demand for physicians in the state of Illinois. Many of our graduates after internship, residency training program, and military service, find very tempting fields in other states of the union. For instance, there is California where the training of physicians has lagged greatly in relation to the population explosion of that state.

Very few people realize that the Department of Registration and Education in the State of Illinois has issued some 2,300 licenses to foreign physicians to practice here.

The decision of the department to enforce the Medical Practice Act in 1964 has resulted in problems for some hospitals where house physicians have not been licensed. However, it is the responsibility of the state medical society and members of the profession to see that the physicians practicing medicine and serving our citizens comply with the law. This is one means of assuring the best medical services possible.

Cost of Care

With the ever-increasing inflation in America, the cost per patient day of hospital care continues to rise 4% to 5% per year. The cost of any hospital service is influenced greatly by the cost of labor. Today, roughly 70% of the hospital overhead is due to labor costs which continue to spiral upward.

The importance of utilization committees in hospitals has been stressed repeatedly during the past several years. The advantageous use of hospital beds possible through advances in medical research and modern treatment should lower the demand for additional new beds. The chief of the medical staff, as well as the hospital administrator, should encourage a very active utilization committee to assist in getting the maximum use out of the beds available to fulfill the demands for hospital care in the area.

Distribution of Physicians

Organized medicine is interested in serving all citizens in the state of Illinois. There is no shortage

of physicians in our larger cities. In a city practice the physician's time in his office and in his hospital can be distributed efficiently to meet the medical demands of his patients on a day-to-day basis. Emergencies in contagious diseases, or disasters will require physicians to work overtime to meet the demands of the citizens.

Rural areas need not only additional physicians but also might be helped by a more efficient use of the time which is available. Hill-Burton funds have been used wisely in the state of Illinois to provide hospital facilities in the rural areas. The utilization of all of these hospital facilities plus physicians' services and time, has to be studied to provide service to patients and satisfaction to physicians. There is no single remedy today which can be applied uniformly to local areas to work out the problems of rural medicine.

Physicians' Civic Responsibility

It was extremely gratifying to me as I traveled to many areas of the state to meet not only the leaders of the medical profession but also civic leaders, members of service clubs, etc. I found physicians leading civic groups in their local communities. Leadership must begin at the local level, and it is the responsibility of physicians to stimulate the interest necessary to provide the health services needed in any community.

Physicians in Illinois have taken a great interest in civic affairs. They have donated not only time but money to improve local hospitals, education, recreation, and church facilities, as well as provide scholarships for the student educationally proficient and worthy of additional schooling. It was a great pleasure for me to present a check for \$187,500 to the American Medical Association Education and Research Foundation. Since these funds are not restricted, the \$20 from each physician member of the Illinois State Medical Society has provided the deans with the opportunity to assist students or faculty members in our five medical schools. I urge the continuation of this support.

Medical Insurance

On Feb. 5, 1965, the Health Insurance Institute reported that by the end of 1963 a record of 77% of the United States civilian population had some form of health insurance. To be more specific, in those days of debate over medicare, the five general classes of such protection stood this way:

"Hospital insurance—145.3 million

"Surgical insurance—134.9 million

"Regular medical insurance—102 million

"Major medical insurance—42 million

"Loss of income insurance—46.9 million

"Paying the doctor bills has always been a problem. Once it was a lonely, individual problem, but in recent decades, new group solutions have been sought. In some countries—notably Britain and the Scandinavian nations—it turned out to be state, or socialized medicine.

"The distribution of the public's medical dollar in the United States in 1963 included:

"32¢ for hospital services

"29¢ for physicians' services

"24¢ for medicine and appliances

"10¢ for dentists

" 5¢ for other"

These are the facts of American medicine which should be well known to all of our population as well as our legislators.

Illinois Association of the Professions

The Illinois State Medical Society can be extremely proud of its part in the formation of the Illinois Association of the Professions, a professional group including medicine, dentistry, law, architecture, engineering, veterinary medicine, and pharmacy, and a new organization, the Illinois Association of Certified Public Accountants.

IAP, devoted to "upholding the dignity of the professions," will continue to strive for high standards which have been established by the professions in serving our citizens. We can be proud that we have had a hand in its formation.

Acknowledgements

I take this opportunity to thank everyone individually for the cooperation that I have received during my year as President of the medical society.

I wish to acknowledge the accuracy with which the newspapers, the radio and television stations in Illinois presented the facts on Illinois medicine. Medicine appreciates this cooperation.

We salute Governor Kerner not only for the attention that he has given the medical profession and the hospitals in his State but also for the time he has spent demonstrating his interest in the welfare of its citizens.

Illinois is the sixth richest state in the union. It cannot look to Washington to provide health programs that it should be developing itself.

Dr. Yoder has given Illinois quality public health, unsurpassed anywhere. We must continue to provide outstanding public health services.

Dr. Gerty and Dr. Visotsky have lead Illinois in the march toward better care of the mentally ill and have made steady progress in the modernization of treatment centers and facilities throughout the State.

Harold Swank, Executive Director of the Illinois Department of Public Aid has given his cooperation and has contributed to a good medical program for the needy.

All of the members of the Board of Trustees have given me advice and counsel, and have provided the incentive to do a good job.

Especially, I request recognition for the chairman of the committees, on which some 2,000 doctors have served their county, state, and American Medical Association.

Now, a personal greeting to each of the 10,500 members of this Society who have given so much

time and effort to maintain our high standard of medical care.

I want to thank the woman's auxiliaries for the great work they have done in the interest of good medicine and I pause to pay special tribute to the wives of doctors who have worked so loyally with their husbands in the all-out effort to improve the physician-image before the population today.

Edward A. Piszczek, *President*

PRESIDENT-ELECT OC-2

Your President-Elect has been fairly busy since our meeting a year ago and it certainly has been an education to live through some of the crises that we have gone through during the past year—particularly, with reference to Medicare and Eldercare. Starting back in the fall of 1964, I had the pleasure of meeting with the Board of the Woman's Auxiliary of the Illinois State Medical Society at which time numerous problems were discussed.

I have attended several meetings of the Council on Medical Service of the American Medical Association with reference to the problem of Medicare and Eldercare and it was our privilege to bring out recommendations for the bill which is now known as Eldercare. We feel that this a comprehensive program, one that every doctor can buy, one that can be serviced by private insurance and the Blues, and one which will leave the major portion of the administration to the states. It also reduces considerably the amount of red tape necessary to establish eligibility. The latter two would have been rather severe stumbling blocks in the way of Kerr-Mills.

I attended the AMA Kerr-Mills conference which brought together from all over the nation representatives from each state discussing the shortcomings and benefits of Kerr-Mills in their state. This was a most enlightening session and indicated areas in which much improvement could be made in Kerr-Mills.

I attended the St. Clair County Medical Society's Ladies Night meeting in Belleville at which time Dr. Donovan Ward, President of the American Medical Association, spoke at the banquet. There was a remarkable attendance, apparently about 400 people, both medical and non-medical turned out. I also attended the Call Session of the House of Delegates of the American Medical Association and the Call Session of the House of Delegates of the Illinois State Medical Association, both of which accomplished the major portions of the things that we desire. It is obvious that our friends are strongly for us and our opponents certainly attempt to throw road blocks in the way at every possible opportunity.

There will be a meeting of the Illinois Legislative and Public Affairs Conference in Springfield on Feb. 23, 1965, at which I will be present sharing

the afternoon session and giving the address of welcome.

I am also appearing before Rotary clubs, Kiwanis clubs, and various other groups telling the story of Eldercare and Medicare with a remarkable reception. It is apparent that many people have no idea what Medicare means nor what it offers. They have no idea as to the amount of taxes concerned nor whether it is for the needy or for anyone rich or poor regardless of ability to pay. It is my opinion that if we spread the gospel properly that there is still a possibility that we can save the day in so far as Medicare is concerned for this session of Congress.

I am looking forward to my year as President of the Illinois State Medical Society. I feel it is a great honor and I trust that I can do it justice.

Burtis E. Montgomery, *President-Elect*

FIRST VICE PRESIDENT OC-3

As your first Vice President, it has been a privilege to attend all the Board Meetings. One is greatly impressed by the volume of business and the dispatch with which it is handled.

It has been educating and indeed pleasurable to substitute for the President at various functions such as the Veterinarian's annual dinner, the Planned Parenthood meeting and luncheon, the dedication of the new Illinois Masonic Hospital library and the interview with Chuck Percy during the recent political campaign.

Carl F. Steinhoff, *First Vice President*

SECOND VICE PRESIDENT OC-4

No report to be submitted.

L. T. Fruin, *Second Vice President*

SECRETARY-TREASURER OC-5

There is no 40-hour week for the medical profession—nor for a medical administrative staff. The individuals in both of these dedicated professions spend many hours, days, nights and weekends accomplishing their duties and obligations, without fanfare, praise, extra compensation and, unfortunately, too often without acknowledgment. I consider it a privilege to publicly recognize these facts and report to you the dedicated endeavors of the entire staff of the Illinois State Medical Society, and to thank them on behalf of the membership for all the constructive work being done for the physicians of Illinois. I would also be negligent if I did not record the maelstrom of activity—day and night—taking place at "Headquarters" during the

Illinois Medical Journal

past several weeks in implementing the Eldercare Program authorized by the House of Delegates on Feb. 7, 1965. The seemingly impossible was made possible by the coordination in staff organization developed during the past five years, from Executive Administrator to copy boy, enabling Illinois to lead the field in the scope, timing and completeness of this campaign to save medical care from federal domination. I would recommend that the 1965 House of Delegates express its appreciation of the dedication and accomplishments of our staff by an appropriate resolution.

House of Delegates Minutes

The actions of the 1964 House of Delegates Annual Convention were provided in abstract form to all delegates by mail about one week after the conclusion of the meeting, and to the membership as a part of the June issue of the *Illinois Medical Journal*. The complete stenographic transcript of any session of the House of Delegates is always available to any interested member of the Society upon request to the Secretary-Treasurer or the Executive Administrator. However, to emphasize actual results and to avoid further demands upon the time of the House, the abstract form of the minutes will be acted upon (as in the past) as the official minutes of the 1964 session.

A special meeting of the ISMS House of Delegates was called by the Board of Trustees (upon recommendation of the Finance Committee) for Feb. 7, 1965. The specific purposes for calling the meeting were:

- (1) "to explain the Illinois State Medical Society's educational campaign, in co-operation with the American Medical Association, relating to national health legislation, including but not limited to policy concerning health care for the needy, and
- (2) "to counsel with the official representatives of county medical societies regarding the various mechanisms by which this educational campaign may be financed."

The actions of the special meeting of the House were provided in abstract form to all members of the House and all county society officers by mail within one week following the meeting. The abstracts were published *for the benefit of each member* as part of a special *Illinois Medical Journal* insert section in the March issue of IMJ.

Follow-up on directives and assignments by the 1964 House of Delegates has been implemented by the Board of Trustees and staff throughout the year. The Executive Administrator and his staff have devoted a sizable share of their efforts during this period to the maintenance of a "log" of each action requested and the individuals assigned responsibility for achieving completion of each request. In every case, the request by the House has been acted upon promptly and completely. More details on this subject will be found in the report of the Chairman of the Board of Trustees.

Billing Procedures

During 1964 a new billing form was developed and mailed to county secretaries for use in the 1965 dues billing. The form was in quadruplicate and provided a timesaving and uniform method of billing for all counties. Revisions are being made for next year's supply, according to suggestions received from various county secretaries.

A departure from the usual procedure of having each county collect its members' dues was made for the collection of the 1965 dues increase voted by the special meeting of the House of Delegates on Feb. 7, 1965. Direct billing from the state office was an option offered county secretaries. Several component societies accepted this offer. Whether such a plan would be desirable for the collection of annual dues is a matter which should be considered in the future.

Communication with Members

Added to the communications methods reported upon in my last two annual reports, during the past year the members of the House of Delegates have been added to the list of individuals receiving the abstracted minutes of each meeting of the Board of Trustees. By doing this, it is hoped that each officer and delegate in each county society will always be up-to-date on the current activities of the state society. We hope these Board minutes have been helpful to the delegates in remaining abreast of actions affecting the medical practice environment.

The oft quoted statement, "The informed citizen is the cornerstone of democracy," is no less true for the members of this Society in the quest for an active and strong state medical society. In the continuing attempt to effectively communicate with each and every member, the publications of the past have been continued and various mailings on specific subjects have been made. The *Public Affairs Newsletter* has been expanded and increased in its coverage. For the first half of 1965 the legislative bulletin *On the Legislative Scene* will be mailed on a weekly basis to a large segment of the membership. Starting in May, the Public Relations bulletin, *The Pulse*, will be removed from the *Illinois Medical Journal*, expanded to eight pages, and mailed to all members on the first of each month. I would like to emphasize that every member of the Society is entitled to receive all of these bulletins; if they are not being received, send name and address to Mr. Robert L. Richards, Executive Administrator, 360 North Michigan Ave., Chicago, Ill. 60601.

The Administrative Staff

It is now five years since the reorganization of the administrative staff of this Society. During this period of time many changes in the activities of the Society have taken place, existing programs expanded, new projects instituted, additional services provided, and better liaison developed with

component societies and individual members.

That this has been accomplished is a matter of record; less well known is how it has been done and by whom. I am certain the membership will be interested in the tabulation of staff organization as developed since January, 1960.

During the five-year period it has been customary—as a matter of fact, it has been necessary at times to make major shifts in assignments for employees. The number of employees listed after each division as of January of each year do not necessarily reflect themselves in the total number of employees for each year.

The following statements regarding major staff additions throughout the five-year period will be helpful in understanding the tabulation.

As of Jan. 1, 1960, there were 16 employees of the state medical society, four in Monmouth; 11 in Chicago, and one legislative representative in Springfield.

In May of 1960, a projected Chart of Staff Organization was authorized by the House of Delegates, and 28 full-time positions were included, and described in the report of the Executive Administrator.

In 1963 additions to the staff occurred when two employees were authorized by the Board of Trustees for the administration of the Educational & Scientific Foundation of the Illinois State Medical Society. The salaries of these employees have been virtually self-sustaining by means of grants to the Foundation for projects since that time. Also a third person was added because a former full-time employee requested to be retained on a part-time basis, and the major portion of her full-time salary was then used to employ an additional full-time clerk-typist.

In 1964, a major realignment of the staff was made in order to create a Division of Economics and Insurance. This in itself did not add any new employees. However, the institution of a Public Affairs Program, authorized by the Board of Trustees, increased staff by the employment of a Director of Public Affairs and a secretary under the Division of Legislation and Public Affairs.

In 1965, one full-time staff member serving the Journal was changed to a part-time Assistant Editor. Also added to the Public Relations staff were the services of one part-time secretary, the major portion of whose salary is principally paid for by the Illinois Association of the Professions.

Secretaries' Conference

The 1965 Secretaries' Conference—a meeting of county society physicians and executive secretaries is scheduled for Apr. 4, 1965, at the St. Nicholas Hotel in Springfield. The program this year will follow the same successful format used in 1964, with round-table sessions following individual presentations on matters of the most vital, up-to-minute importance to the Society's members. The

Staff Organization as of . . .

	1/1/61	1/1/62	1/1/63	1/1/64	1/1/65
Administration	3	4	6	6	6
Business Services	7	8	5	6	6
Public Relations	4	4	5	5	6
Legislation & Public Affairs	3	3	5	6	6
Springfield Regional Office	4	4	3	3	3
Economics & Insurance	0	0	0	2	2
Publications & Scientific	4	2	2	2	2
Illinois Medical Journal	5	5	5	4	4
ISMS Foundation	0	0	2	1	1
Total Number of Employees	30	30	33	35	36
Number of Full time employees	26	27	28	30	29
Number of Part time employees	4	3	5	5	7

round-tables are staffed by resource personnel and are organized by program area (Legislation, Economics, Business Services, Public Relations, etc.). Conference participants are free to move from table to table to obtain answers to questions affecting their county society.

Representatives from each county should make every effort to attend this annual session in order to obtain the wealth of information and data available. Each county society delegate can attend the annual convention better supplied with background information relating to the Society's activities over the past few months if each county secretary attends and brings to him the material inter-exchanged at this conference.

The support of each county society secretary is vital to the success of the efforts on the part of the officers and committee members of the state society. Only by receiving a prompt and complete response from each county when action and response is requested can a total and effective program be carried out.

Membership

The membership changes indicated in the table of statistics shown below relate a slight increase during 1964 in number of ISMS members. The ISMS policy of granting new members in practice a 50 per cent dues reduction in their first year of membership has been of great assistance in encouraging these new memberships.

Our present dues policy also authorizes a 50 per cent dues reduction for members in the full-time employment of an approved medical school or a not-for-profit institution. Many physicians, working for improvement in the community's health

through full-time employment in state and federal hospitals and other government-affiliated institutions, do not feel financially able to participate in the activities of the Illinois State Medical Society. I would like to recommend that the House of Delegates give consideration to a similar 50 per cent dues reduction for all members not in private practice and in the full-time employment of any government-affiliated institution or department.

Examples of such government-affiliated institutions would be the VA hospitals, state and county hospitals, health departments and agencies, etc.

MEMBERSHIP STATISTICS

Membership as of		
January 1, 1964		10,145
New members	537	
Reinstatements	211	
Total added		748
		10,893
Dropped during the year:		
Died	175	
Moved from State	47	
Resigned	7	
Nonpayment	164	
Total dropped		393
Membership as of		
Jan. 1, 1965		10,500
Regular		
Residents	230	
Service	30	
Emeritus	459	
Retired	312	
Hardship	31	
Intern	26	
Total	10,500	

1964 and 1965 Budgets

In order to pursue the active public affairs-information program that the House of Delegates and Board of Trustees desired accomplished, the annual budget for 1964 was revised and approved by the Board of Trustees to include a deficit of \$21,500, as of July 1, 1964. The original budget for 1964, approved in January, showed a deficit of \$32,750.

There was no desire or intention by the Board of Trustees to accept a deficit without making every effort to achieve a balanced budget. As I stated in my report last year: "There is no assurance that the net deficit for 1964, if indeed a deficit does develop, will necessarily total \$32,750. Your officers, committee chairman, and staff will certainly exert every effort to conserve finances and obtain every economy of operation that is possible. However, *we cannot allow medicine to lose its rightful progress and freedom for the lack of support represented by the necessary dollars.*"

The Board of Trustees, at its meeting in Jan-

uary, 1965, approved an initial expense budget for 1965 totaling \$718,200, including a *potential* deficit of \$28,200. This was done after mature consideration and reconsideration, for only matters of the utmost urgency could have caused the Board to approve two consecutive deficit budgets. But the terms of medicine's battle have changed considerably, and this war, too, has escalated into a much sharper focus. Surpluses developed in prior years would have no meaning if they could not be used in times of financial crisis, and the years 1964-65 have witnessed the sharpest attack to date upon the American system of medical practice.

Since the adoption of this budget, however, other major factors have been introduced into the financial picture. A special meeting of the House of Delegates on Feb. 7, 1965, authorized the expenditure of approximately \$252,000 to program in Illinois the AMA Eldercare Plan, and a \$25 per capita dues increase for 1965 to finance the costs.

A supplementary report concerning the expenditures and income on this project will be made by the Finance Committee at the annual convention.

Investment of Reserves

At the end of 1964, the General Fund reserves totalling \$144,000 were invested under the supervision of the Continental Illinois National Bank trust department. Of this amount, 25 per cent was invested in U.S. Government bonds, 36 per cent was in bank savings accounts, and 39 per cent was invested in investment-grade common stocks.

Benevolence Funds reserves have also been included in this investment program. They totaled approximately \$147,000 on December 31, 1964. Of this total, 40 per cent was in U.S. Government bonds, 5 per cent was in bank savings accounts, and 55 per cent was in common stocks.

All investments are made upon recommendation by the bank, after review and approval by the Finance Committee of the Board of Trustees. Custody of all securities is maintained by the bank, and monthly reports of principal and income are made to the Society.

Income from all investments amounted to \$15,140 in 1964, compared with \$17,160 in 1963, and \$14,830 in 1962. Investment return is subject to variation from changes in the national money-market and the timing of the Society's cash requirements. We constantly seek, however, to maximize the return from our investments, consistent with a minimization of risk of loss.

As an example of the results possible with the assistance of modern investment counsel, the General Fund Investment Trust account was yielding 3.60 per cent annual return on common stock investments as of Jan. 11, 1965. Several investments are now yielding over eight per cent, five per cent and four per cent on each dollar invested because of the increase in corporate net income and common stock value. Our General Fund bond investments were yielding four per cent as of Jan. 11, 1965.

On Jan. 11, 1965, there was unrealized market gain totaling \$20,982 on a total common stock investment of \$55,435 in the General Fund. At that date, the Benevolence Fund had an unrealized market gain of \$17,467 on a total common stock investment of \$58,931. The more conservative common stock investments of the Benevolence Fund are yielding 4.37 per cent on cost as of Jan. 11, 1965.

Financial Statements for 1964

Condensed financial statements are presented here for the benefit of the entire membership. The

complete audit report for the year ended Dec. 31, 1964, will be provided to each member of the House of Delegates. Copies of the 1965 operating budget, as approved by the Board, will be made available to the appropriate reference committee for its consideration and comment. Dr. Clark, chairman of the Finance Committee; Mr. Richards, the Executive Administrator; Mr. King, Director of Business Services; and myself will be available at the reference committee hearings to assist in any way possible.

ILLINOIS STATE MEDICAL SOCIETY

POSITION STATEMENT—DEC. 31, 1964

	Total	General Fund	Benevo- lence Fund	Equipment Replace- ment Fund	Student Loan Fund	Property Fund
<i>ASSETS</i>						
Cash	\$ 76,000	64,062	7,666	4,272		
Receivables	27,987	23,444	4,247	296		
Investments, at cost	253,993	92,107	139,935		21,951	
Student loans	78,945				78,945	
Prepayments and advances	8,083	8,083				
Office furniture and fixtures	65,212					65,212
Total Assets	\$510,220	187,696	151,848	4,568	100,896	65,212

LIABILITIES AND FUND BALANCES

Payables	\$ 8,766	8,766				
Accrued expenses	2,250	2,250				
Deferred income	3,575	3,575				
Fund Balances	495,629	173,105	151,848	4,568	100,896	65,212
Total Liabilities and Fund Balances	\$510,220	187,696	151,848	4,568	100,896	65,212

INCOME STATEMENT—GENERAL FUND—YEAR ENDED DEC. 31, 1964

<i>INCOME</i>		<i>EXPENSES</i>	
Membership dues—		Board	\$ 35,559
Basic dues—\$80 per member	\$751,896	ISMS and AMA Meetings	60,887
Less allocations:		Administration	68,251
American Medical Association—		Business Services	71,054
Education & Research		Springfield Office	42,700
Foundation—		Public Relations	93,200
\$20 per member	187,850	Legislation and Public Affairs	100,428
Benevolence Fund—		Economics and Insurance	29,024
\$2 per member	18,785*	Publications and Scientific Services	39,656
Total allocations	206,635	Illinois Medical Journal	107,720
Net membership dues	545,261	Non-departmental	61,616
Illinois Medical Journal	89,400	Total Expenses	710,095
Annual Convention exhibits	16,268	Excess of Expenses Over Income	\$ 31,339
Interest & dividends	15,373		
All other	12,454		
Total Income	\$678,756		

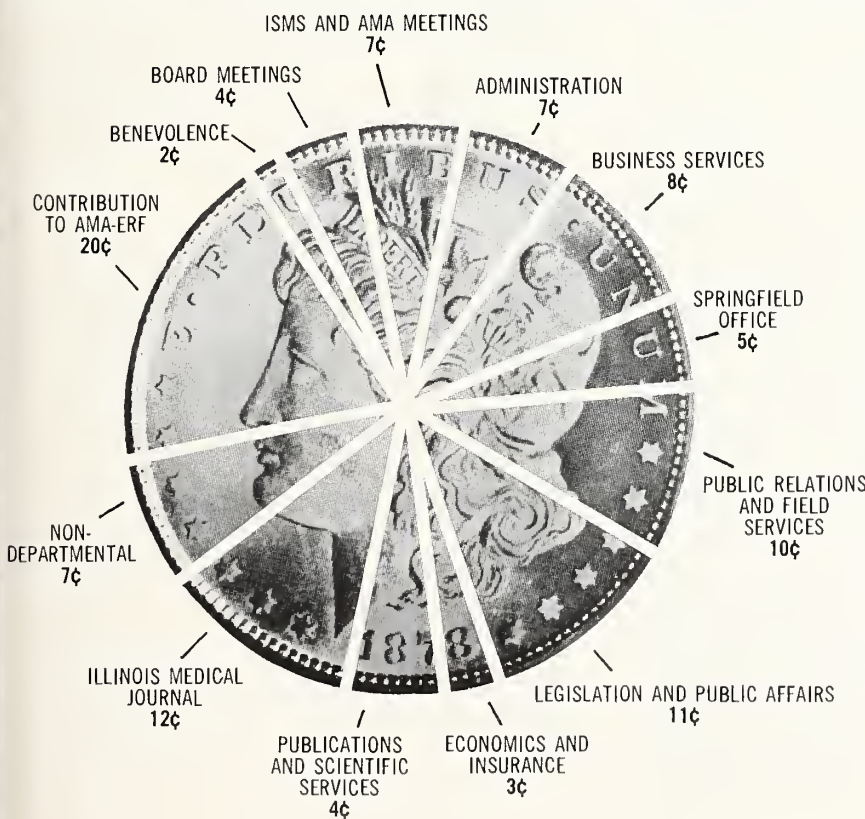
*1964 assistant payments totaled \$34,860

WHERE THE ISMS GENERAL FUND DOLLAR CAME FROM in 1964

Membership Dues	\$751,900
Illinois Medical Journal	89,400
Annual Convention Exhibits	16,300
Interest & Dividends	15,400
All Other	12,400
Total	\$885,400



HOW THE ISMS GENERAL FUND DOLLAR WAS SPENT in 1964



Contributions To-AMA-ERF	\$187,800
Benevolence	18,700
Board Meetings	35,600
ISMS and AMA Meetings	60,900
Administration	68,300
Business Services	71,100
Springfield Office	42,700
Public Relations & Field Services	93,200
Legislation & Public Affairs	100,400
Economics & Insurance	29,000
Publications & Scientific Services	39,700
Illinois Medical Journal	107,800
Non-Departmental	61,500
Total	\$916,700

SPEAKER AND VICE SPEAKER OC-6

It is the opinion of the Speaker and Vice Speaker that the 1964 meeting of the House of Delegates functioned at a high level of efficiency resulting from the most able direction of our past Speaker, Dr. Walter Bornemeier, and the active participation of the officers, trustees and members of the House of Delegates.

The special meeting of the House of Delegates in February, 1965, which was called for the consideration and financing of the informational program on proposed legislation on health care of the elderly, was featured by the adherence to a rigid time schedule by the participants in the morning's agenda, the excellent conduct of the hearing and rapid preparation of a report by the very effective reference committee and the perfect cooperation of the members of the House of Delegates in limiting their discussion to pertinent matters and keeping their remarks as concise as possible. We were honored to have Dr. Donovan F. Ward, President of the American Medical Association, and our own Dr. Percy Hopkins, Chairman of the Board of Trustees of the American Medical Association, address the House of Delegates.

Convention Schedule Changed

As recommended by the Committee on Scientific Assembly and approved by the Board of Trustees, a change will be made in the schedule of the May, 1965 House of Delegates meeting. The House will convene at 3 p.m., Sunday, 3 p.m., Tuesday, and 2 p.m., Wednesday. The latter session will open with the Camp Memorial Lecture (open to all physicians). Reference committees will meet at 7:30 p.m. Sunday following a buffet supper and on Monday morning if necessary. In order to conform to the new schedule some innovations will be suggested to facilitate and expedite the work of the House. Following the recently introduced policy in the American Medical Association House of Delegates, it will be suggested that resolutions might be introduced by title only rather than reading the resolves or the entire resolution. However, each delegate must continue to have the privilege of determining the manner in which his resolution is to be introduced. In an effort to further conserve time, and hold the attention of the House of Delegates, a modification will be suggested in the preparation and presentation of Reference Committee reports. It should not be necessary to adopt a Reference Committee report paragraph by paragraph. We refer particularly to many non-controversial committee reports not requiring action other than accepting the committee report. Comments on such reports might be placed in the concluding paragraphs of the Reference Committee report. The final motion to approve the adoption of the Reference Committee report as a whole, should cover such matters. Those sections of the Reference Committee reports requiring definite action by the House of Delegates must continue to be discussed and voted upon as individual

items. A member of the Board of Trustees has been assigned to serve with each Reference Committee in an advisory capacity. Staff will be available for assisting in preparation of the Reference Committee report.

New Election Plan

Consideration should be given to a method of conducting a more efficient election of officers at the last session of the annual meeting. In the past, the election has been time consuming in spite of the fact that the officers are actually selected at the caucuses. At the House of Delegates meeting in 1965, a plan will be suggested regarding presentation of nominations and final election of officers in a less time consuming manner, which will be consistent with our constitution and acceptable parliamentary procedure.

County societies should make every effort to forward resolutions in sufficient time to be published in the April issue of the Illinois Medical Journal. This provides the opportunity for delegates to review resolutions with their county societies.

The speakers wish to commend the chairmen and members of the Reference Committees at the 1964 session and the special session held in February, 1965, for the efficient manner in which they conducted the Reference Committee hearings and in the preparation of their reports. The members of the House of Delegates should be commended for their active participation in the Reference Committee hearings. Such participation not only reduces the amount of controversial discussion before the House of Delegates when the final report is being considered, but provides the members of the Reference Committee with the consensus of those appearing before them. All members of the Illinois State Medical Society may be heard at Reference Committee hearings.

Improved Operations Sought

A permanent hand book is being prepared for the instruction of delegates and should be in the hands of each delegate before the 1965 meeting. The purpose of the handbook is to provide members of the House of Delegates with information which should help them fulfill the important responsibility which has been entrusted to them by their county medical societies.

Although a request has been made from the members of the House of Delegates for suggestions regarding the operation of the House for the 1965 session, none has been received. However, every attempt should continue to be made to improve the conduct of the House and suggestions will be welcomed from all delegates.

The speakers wish to thank the members of our fine staff for their invaluable assistance and cooperation in the preparation and conduct of the meetings of the House of Delegates in May, 1964 and February, 1965.

Edward W. Cannady, *Speaker*
Maurice M. Hoeltgen, *Vice Speaker*

TRUSTEE REPORTS

FIRST DISTRICT T-1

The First District, having initiated a policy of several interim meetings of delegates during the year, plans to continue such a practice. These meetings have proven to be a very effective means of drawing the delegates into the affairs of the House of Delegates. They can come to the meetings informed and having had the opportunity to get the opinions of their members before going to the meeting of the House of Delegates.

The District Aging Committee is in the process of organizing and producing a program on aging. This is a pilot program assisted by the state society staff.

No counties of this district have, as of this writing, initiated resolutions, but several societies have gone on record as supporting resolutions of others.

There is satisfactory progress among the county societies of the First District in nearly all respects of organizational endeavor.

Like all previous years, the three highly organized counties of Kane, Lake and Winnebago have covered the full span of projects as outlined and requested by the state society.

Kane County has been most active in the field of public affairs, while also maintaining a well rounded program in both the branches and the society. They also maintained community programs, sponsored by the society throughout the many cities of their area.

Lake County, besides a full program like the others, has been a leader in promoting an inter-professional group on the local level.

The annual report of Winnebago County indicated that participation in both society and community affairs was extensive. Members expended many man hours and their efforts have been well received and were effective in these fields.

There is an improved grass-roots attitude in all other seven smaller societies. These societies have maintained regular meetings and have responded well when called upon to initiate or promote activities. The interest in organized medicine appears to be at an all-time high in the First District. Perhaps this is due to the urgency of the present problems confronting medicine. This has been most apparent in the two district meetings which were held.

The Trustee has conferred several 50-year certificates which is always a pleasure and provides an opportunity to communicate with members.

I wish to thank these members and delegates for their loyal support. It continues to be a rewarding experience.

Carl E. Clark, *Trustee*

SECOND DISTRICT T-2

At the time of the preparation of this report there are not any resolutions from the county societies for presentation to the House of Delegates at the annual meeting in May, 1965. We hope that in the year ahead that there will be a district meeting combining the joint efforts of the Scientific Service Committee and the Public Affairs Committee.

The county medical societies of the Second District have enjoyed a year of activity through the competent leadership of their officers and committees. Whiteside County Medical Society is in the process of setting up a fund to aid students in medical schools and students in medically-related subjects such as x-ray technicians, physiotherapists, nurses, etc. This is very commendable. Bureau County Medical Society has established an annual scientific meeting designed to attract professional attendance from beyond its own county, and it is meeting with success. LaSalle County Medical Society presented a Public Affairs program at which Congresswoman Charlotte Reid was the principal speaker. It was a great success, and the county committee on arrangements is to be congratulated. The Livingston County Medical Society held a combined meeting of their members with the Bar Association of Livingston County. The meeting was well attended and it is a meeting such as this that promotes a better understanding between the two professions.

The county societies have held periodic scientific meetings, with the speakers chosen either from the scientific programs presented by the Scientific Service Committee or from the speakers supplied by foundation programs.

It has not been necessary to convene the Ethical Relations Committee, the Grievance Committee or the Prepayment Plans Committee of the district during the past year.

The Second District was well represented by the delegates of component societies at the special meeting of the House of Delegates, Feb. 7, 1965. Every doctor should realize that the medical profession cannot interest others in extremely important socio-economic problems unless the individual doctor acquaints himself with pertinent facts and takes a positive action.

Your trustee presented two 50-years in practice certificates during the past year. Your trustee is an ex-officio member of the Committee on Legislation and a member of the Finance Committee.

I wish to express my gratitude to the officers and members of the county societies for the cooperation and the courtesies extended to me. It has been a privilege to work with the officers and trustees, and committee members of the Illinois State Medical

Society. I wish to thank the headquarters staff in both the Chicago and the Springfield offices for the help and cooperation given to me.

Ralph N. Redmond, *Trustee*

THIRD DISTRICT

T-3

Report not available for publication.

Caesar Portes, Frank J. Jirka, Jr.,

Philip Thomsen, J. Ernest Breed,

William E. Adams, Ted LeBoy,

Trustees

FOURTH DISTRICT

T-4

The past year has been lively with many projects to demonstrate an ever increasing interest in public relations reciprocated by a healthier attitude of the public toward the medical profession:

1. One society cooperated with local officials to legislate an ordinance regulating the operation of ambulances with that city.
2. Another unit has supported an ordinance to require annual chest x-rays for all food handlers with its city.
3. Interest has increased in civil defense activities with professional sponsorship of classes in medical preparedness.
4. One society has conducted weekly radio programs on medical topics with exceptionally good acceptance.
5. District-wise, there has been active support of Medic-Alert; Mental Health Programs; and Home Care plans.
6. Peoria Medical Society is working actively with state legislators in an attempt to provide a medical school within its area.

Two important projects now engage the interest of the Fourth District of the Illinois State Medical Society.

1. Operation Hometown:

The educational aspects are well organized with civic and paramedical cooperation excellent. Monetary support is much encouraged.

2. Illinois Association of Professions:

Enlarged interest in the Illinois Association of Professions, an inter-professional organization, is our aspiration for 1965-66. One chapter has already been organized within the district.

Among Fourth District membership there has been an increase, not only in numbers, but in interest and cooperation.

1. The few minor problems that have arisen have been adequately settled.
2. Postgraduate sessions have been presented.
3. It is recommended that several counties combine wherever geographically feasible to present these and other scientific programs.
4. Some of our members have had scientific ar-

ticles published during the year. This is commendable.

5. Several county societies have sent, regularly, correspondence concerning activities within their units. For this your trustee is most grateful.

Grateful acknowledgment is extended from the Fourth District to AMA President Ward who has appeared as speaker for us; to the splendid staff at Illinois State Medical Society headquarters for their patient guidance; to all local society presidents for their energy expended; and to the press, radio, and television media for their enthusiastic cooperation throughout the year.

Paul P. Youngberg, *Trustee*

FIFTH DISTRICT

T-5

The undersigned trustee was removed as perennial delegate from Sangamon County to neophyte trustee of the Fifth District, Illinois State Medical Society, by the annual election in May, 1964.

During this year, the eight component county societies have continued to be active and cooperative in state society projects. Most of the component societies conduct monthly meetings with good scientific programs.

Under the supervision of Dr. Jacob E. Reisch, the Illinois State Medical Society had an outstanding exhibit at the Illinois State Fair for the 14th consecutive year. The Sangamon County Medical Society Auxiliary once more provided yeoman service handing out literature and answering questions. This single project affords us a great outlet for preventive medicine information as well as information regarding the goals and objectives of organized medicine. The fair goer by and large is our friend and neighbor. I would urge that we continue to give this project high priority and support.

The Sangamon County Medical Society bulletin continues to be an outstanding publication. This too is one of many facets of Dr. Reisch's contribution to our society having served as editor from January, 1948, until October, 1964. It continues on under the editorship of Dr. Donald Yurdin of Springfield.

The Fifth District Postgraduate meeting was hosted by Logan County Medical Society, Nov. 5, 1964. This was a most successful meeting in all aspects except for attendance. A total of 21 doctors representing four of the constituent county societies were in attendance. The doctors of Logan County were most congenial hosts. The program was well diversified and the speakers well fitted for their subjects. The diversification was such that it should be of interest to men in the specialties as well as in general practice. A survey of the members present pointed out that the greatest number of members present came from the smaller county societies rather than the larger societies. Possibly, it would be best to consider holding these post-

graduate assemblies on a regional rather than district basis.

This being a legislative year, the Legislative Public Affairs Conference was again held in Springfield on Feb. 23 with a full day's information program ending with a reception for the members of the state legislature and their wives.

A conclave of the delegates of the Fifth District will be held in Springfield in the near future.

Your trustee plans to visit the component societies, if possible, by the time of our annual meeting in May.

To date, the constitutional committees of the district, namely the Grievance Committee, Third Party Plans, and Ethical Relations Committee have not been convened as no occasion arose which component societies could not resolve.

Your trustee wishes to express his appreciation for the cooperation and kind consideration shown by the membership of the component societies, the officers and delegates of the component societies, my fellow trustees, the State Society officers and last but not least, the state society staff.

Darrell H. Trumpe, *Trustee*

SIXTH DISTRICT

T-6

The county medical societies that make up the Sixth District function efficiently with an alert and cooperative group of officers. The district is fortunate to have members who interest themselves in state and national affairs. The membership of this district remains constant. District committees having to do with ethical relations, prepayment plans, and grievances are organized. It is gratifying that no occasion has arisen which necessitated a meeting of the Grievance Committee.

The Morgan County Medical Society was host for the annual district meeting. Morgan County is famous for its hospitality. Within the district various societies have cooperated with medical self-help programs, programs for the aging, and "Operation Home Town." One of our societies actively participated in an organizational meeting of the Illinois Association of Professions. Each society has regular scientific meetings.

The Sixth District is most proud to announce the organization of the Woman's Auxiliary to the Morgan County Medical Society. This serves to complete the triangle of the District: Morgan, Madison, and Adams. Another auxiliary is planned in Jersey County.

Dr. Earl R. Chamness of Carlinville became eligible and was awarded a 50-year certificate. His pin was presented at a joint meeting of the Macoupin and Montgomery County Medical Societies.

Congressman Paul Findley's stature in Washington has increased and he continues to be a friend of medicine. He is assisted by his own selected committee of physicians.

As your trustee I attended all of the meetings of the Board. To the officers and members of the county medical societies may I extend my thanks for their courtesies, helpful advice, and hospitality. I also wish to thank the officers and trustees of the Illinois State Medical Society and the Executive Administrator and his staff in Chicago.

Newton DuPuy, *Trustee*

SEVENTH DISTRICT

T-7

New members are continuing to come into the Seventh District. The main increase has been eight members in the Macon County Medical Society.

The district committees actions have been confined to the Grievance Committee. This committee was called twice during the past year and solved all problems amicably.

There was no call for the Ethical Relations or the Prepayment Plans Committees.

The outstanding activity within various county medical societies has been in the very successful Sabin oral poliomyelitis vaccination program. This type venture has been a highlight in public relations.

An inter-professional meeting with the professional engineers was held at Decatur in April and was a very good start towards the inter-professional activities being formulated under the Illinois Associations of Professions.

New hospital building is in the near future. The Decatur and Macon County Hospital is putting on a \$4 million campaign for a large addition to the present building. The medical staff has been asked to raise \$300,000 of this figure, and at the latest report approximately four-fifths of this amount has been raised on a voluntary basis.

The new Adolph Meyer Mental Health Zone Center for which ground was broken on Feb. 25, 1964, is rapidly taking shape. And, as reported in the 1964 report, the Centralia Center for the mentally retarded children opened on May 1, 1964.

Your trustee has given much time and effort during the election year. He has been particularly active recently throughout the district on the informational program adopted by the AMA and Illinois State Medical Society Feb. 6 and 7, 1965.

It was your trustee's pleasant privilege to be able to attend the Seventh District meeting of the Women's Auxiliary held in Decatur in October. Our Auxiliary is a very active group to whom we should all extend our appreciation.

One Fifty Year Club award was made during this past year. It was made to Arthur B. Curry, M.D., who was inducted on May 26, 1964, at a regular scheduled meeting of the Macon County Medical Society.

In summary the constituent societies of the Seventh District have been very active during this past year. All are alert and working intensely to block, by information and education to the public, any

socialistic measures being put forth in this present Congress. We pray for success.

Your trustee wishes to extend his appreciation for the cooperation of all the constituent societies and auxiliaries during this past year and particularly the assistance and understanding during a three month period of disability.

Arthur F. Goodyear, *Trustee*

EIGHTH DISTRICT

T-8

No report available for publication.

Wm. H. Schouengerdt, *Trustee*

NINTH DISTRICT

T-9

Your trustee of the Ninth District was elected by the House of Delegates in May, 1964, to fill the unexpired term of Burtis E. Montgomery, M.D., Harrisburg, who was elected President-Elect of the Illinois State Medical Society. Since my election I have faithfully tried to carry out the duties of my office by visiting the following county medical societies—Jefferson-Hamilton, Wayne, Franklin, and Pope-Saline-Hardin. In July, 1964, I presented a 50-year pin and plaque to Dr. W. E. Phillips, Cisne, a member of the Wayne County Medical Society. I have attended all but one of the meetings of the Board of Trustees, and this was missed because of bad weather. I attended the special meeting of the House of Delegates in Chicago, Feb. 7, 1965. I will attend the orientation program for the chairman of the educational campaign in support of the new AMA "Doctors' Eldercare Program" to be held in the 21st Congressional District, Feb. 14, 1965.

During the year no problems for the District Ethical Relations Committee, the Grievance Committee, or the Prepayment Plans and Organizations Committee have been presented.

Articles have appeared in some newspapers in my district as well as in the Tenth District stating that there is a vital shortage of physicians in southern Illinois, especially the 31 most southern counties. A pamphlet, "Number, Distribution, and Age of Physicians in Southern Illinois," was published by Southern Illinois University, Carbondale, which stated that the 700 active practicing physicians in southern Illinois had 1507 patients per physician, and that the War Manpower Commission states when there is only one physician to 1500 patients, the ratio is critical. They further stated that low income among the employed people in southern Illinois was a major factor in preventing physicians from locating here. Factors which they did not take into consideration in their article was that many patients are referred to Paducah, Evansville, Cape Girardeau, or St. Louis for specialists' treatments, nor did they obtain the average age of death of the deaths which occur in the 31

southern Illinois counties studied, nor did they quote statistics on maternal or infant mortality and compare these with statistics from areas where the patient-physician ratio is 1-750.

Their conclusion was that the medical schools of Illinois should train more physicians. This is a fallacy because Illinois trains more physicians with its five Medical Schools than any other state in the union. Perhaps the adequacy of medical care of southern Illinois should be investigated by a committee of the ISMS.

Charles K. Wells, *Trustee*

TENTH DISTRICT

T-10

1. Twenty-five per cent more physicians answered the second annual Newsletter than the first issue. They expressed desire for more opportunities in the state medical society activities for younger physicians, more programs tailored to general practice at annual meetings, and physicians' leadership role in striving to hold down spiraling medical costs.
2. Aug. 5, 1964—Trustee visited Washington County; impressed by members' unanimous enrollment in AMPAC and IMPAC; welcomed Dr. Begelein, a newly located physician.
3. Aug. 18, 1964—Visited Pulaski and Alexander Medical Society, Cairo, at St. Mary Hospital because of IPAC patients. Society advised to activate local advisory committee to prevent situations developing to a degree requiring state level review. Considerable interest by pathologist concerning the proposed research project of testing for alcoholic content of victims of fatal motor vehicle accidents.
4. Sept. 3, 1964—St. Clair County Medical Society and Auxiliary hosts to honored guest Dr. Piszczek, state president, on the occasion of Public Affairs Dinner. Dr. Piszczek was received at the offices of the mayor, Chamber of Commerce, Public Health Center, and a reception was held at the home of Dr. and Mrs. Wilson West.
5. Sept. 16, 1964—Perry County Medical Society visited and the highlights were (1) an understandable concern by two physicians in Pincneyville over compulsory divesting of their inherited interests in a corporation operating a pharmacy; and (2) an informative resume on encephalitis by Dr. Elvin Sederlin, public health officer of Carbondale.
6. Sept. 15-17, 1964—St. Clair County Health Fair held in Belleville; 32 booths, 1,600 visitors; interim report on Laboratory Committee from Dr. Frank Holman, chairman.
7. Sept. 22, 1964—Jackson County Medical Society meeting. At the meeting there was vigorous discussion announcing displeasure with IPAC

drug formulary. Dr. Weatherly announced his candidacy for trustee of Illinois University. The society is enthusiastic, progressive, and represents one of the most important medical sources in southern Illinois.

8. *Sept. 30, 1964*—Attended legislative conference held by Legislative Committee of St. Clair Medical Society. Richard Lockhart was guest speaker.
9. *Oct. 1, 1964*—St. Clair County Medical Society hosts to representatives of local bar association for a program on IMT presented by Mr. Pfeifer of Springfield.
10. *Nov. 5, 1964*—Augustine's Restaurant, Belleville; Ninth and Tenth District meeting convened on 90th anniversary of Southern Illinois Medical Society. Dr. Burtis Montgomery elected president. Varied and stimulating program. During business session considerable dissatisfaction with present IPAC formulary. Mr. Richards and Mr. Widner present. Both trustees addressed auxiliary meeting. My remarks on the individual. Attendance 100 physicians, 36 exhibitors, and 65 auxiliary members and guests. Mention made of potential role available to society in leadership role of medical and nursing education.
11. *Jan. 4, 1965*—Visited Union County Medical Society at Union County Memorial Hospital. Discussion included advice for a Censor or Grievance Committee appointment in their society to deal with matters that have been troubling them from the standpoint of public relations. Their local hospital is awaiting decision on examination for accreditation revealed by Mr. Zimmerman, director. The society members are concerned over the lack of young physicians entering the general area and feel medical service may gravitate toward Carbondale area. They were unclear as to the state society and AMA positive program in dealing with the total problem of the aged and desired information along these lines. Wholesome discussions took place. Also, election of officers took place.
12. *Jan. 7, 1965*—Dr. Donovan Ward, president AMA, was guest speaker East St. Louis Chamber of Commerce. Approximately 140 members and guests present; followed by news conference with ABC, NBC, and CBS, and other news media. His performance was considered superior and a theme of his remarks was that the AMA had considered itself to adopt a prudent course and was maintaining it at the present and hoped to pursue it successfully in the future despite political developments to the contrary. At the regular meeting of the St. Clair County Medical Society, he, Mrs. Ward, Dr. and Mrs. Montgomery, and other officials addressed a combined meeting of about 400 people at Augustine's Restaurant including important civic people and educators. He stressed the need for fuller appreciation and develop-

ment of medical auxiliaries, medical assistants' organization and the judicious employment of medical personnel, along with the same theme presented at his luncheon and news conference. In summary this may be considered a professional coup with contemporary organizations in medicine.

13. *Jan. 15, 1965*—Members of St. Clair County Medical Society attended the annual banquet of the Southwestern Division of Illinois Manufacturers Association featuring Dr. Annis who in his inimitable manner left no doubt in the minds of industrial leaders of their role and stake in free enterprise system as now threatened by federal encroachment spearheaded with Medicare.
14. *Jan. 23, 1965*—Combined Ninth and Tenth District Society meeting at Sparta. Election of officers with lively discussion with Mr. Dashner, coroner, over category of coroner cases with special concern of people in nursing homes. Considerable concern over drug formulary and consideration for showing of multiple birth picture at area meeting.
15. *Feb. 14, 1965*—Combined Ninth and Tenth Districts Public Information Orientation meeting, DeSoto, chaired by Dr. Charles Wells, Ninth District, featuring remarks by Dr. Burtis Montgomery, president-elect; Mr. Imboden, field representative; Mrs. Scrivner, State Medical Auxiliary; and W. C. Scrivner, trustee Tenth District; with audience participation. Summary of presentation of visual aids by Cliff Raber on the subject matter, who was also coordinator of the meeting.
16. *Feb. 18, 1965*—Fourth annual banquet in honor of student nurses St. Clair County area sponsored by Nurse Scholarship Association of St. Clair County, St. Clair County Medical Society, and East St. Louis Chamber of Commerce host to 40 student nurses including those on scholarship; approximately 194 people in attendance; a great success by all standards.
17. *Feb. 25, 1965*—Monroe County Medical Society; current legislative matters, national and state, dealing with Eldercare, physicians' licensing, and medical society services were chief items of discussion by members and trustee.

Remarks

The shortage of general physicians and their unequal distribution throughout the district continues to be of primary concern to all interested parties.

My sincere appreciation to all physicians, officers, and delegates contributing to the medical service excellence, and leadership roles they have performed during the past year.

The entire membership acknowledges with gratitude the many services and assistance rendered by the State Society staff in the conduct of our affairs.

W. C. Scrivner, *Trustee*

ELEVENTH DISTRICT T-11

During the past year the component societies have continued their activity in diversified scientific programs. Operation Hometown Committees in a number of county societies carried out well planned assignments in distribution of new material from the AMA in the Medicare fight, as well as stepping up speaker's bureau activities.

There have been no particular problems in this district during the past year and consequently there was no need to call on the Ethical Relations, Grievance or Prepayment Plans Committees.

Your trustee officiated at the presentation of a 50-year certificate to Dr. Herman J. Adelman. It was also your trustee's turn to receive the 50-year certificate, which was presented to him by Dr. Harlan English, at a meeting of members of the Will-Grundy County Medical Society and the Women's Auxiliary.

During the past year your trustee attended all the meetings of the Board of Trustees. The co-

operation of the Executive Administrator and his staff is gratefully acknowledged.

Bernard Klein, *Trustee*

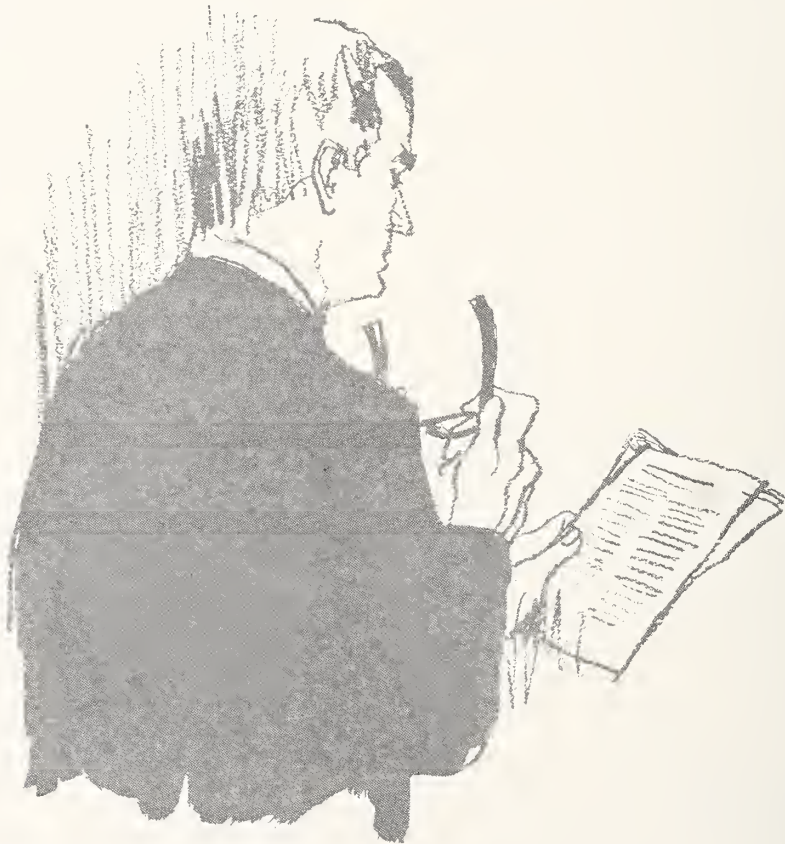
TRUSTEE-AT-LARGE T-AL

The most interesting responsibility of this trustee-at-large has been the continuing one in medical education. As a result of the best thinking of our own trustees we developed a reasonable profile of the future.

Thanks to many stimulating conferences with Dr. Lester Evans, the consultant for the University of Illinois, a very interesting potential program has been suggested for our state. Activities in this area are slow but the results are certainly worth the effort.

It has been a privilege and a pleasure to enjoy the co-operation of so many good people during this year of responsibility.

Harlan English, *Trustee-at-Large*



CHAIRMAN OF THE BOARD OF TRUSTEES S-1

At the first meeting of the Board of Trustees following adjournment of the 1964 meeting of the House of Delegates, William E. Adams, M.D., was selected as chairman. The selection of a chairman-elect at the January, 1964, meeting of the Board permitted a very orderly method of organizing for the year. It made possible for 1964-65 prompt approval of committee appointments. As a result, the activities of committees were instituted earlier than in past years. By taking this action the Board eliminated the customary time lag between the May and July meetings of the Board when committee appointments had previously been approved.

Follow-up on Resolutions of the 1964 House of Delegates

All resolutions considered by the 1964 House of Delegates are reported here as a permanent record of actions taken thereon, as well as the guidance of the Policy Committee in the development of future policies.

Resolution Referred to Reference Committee on Administrative Activities

#64-14 "Summary of Board of Trustees Actions to be sent to members of House of Delegates and other selected persons" by order of the House. *Adopted* and referred to Executive Administrator for implementation throughout the year.

Resolutions Referred to Reference Committee on Constitution & Bylaws

#64-1 "Evaluation of Clinical Laboratories" and the establishment of "District Committees". Changes were made by rewriting Chapter VII to provide for the establishment of "District Committees as needed" in any Trustee district composed of more than one county medical society.

#64-2 First "Resolve" *Not adopted*
Provided for "penalty" in the case of resolutions received after a certain date, and not furnished members of the House prior to opening session.

Second "Resolve" *Referred to Board of Trustees*
To be investigated by an ad hoc committee, and a report presented at the 1965 meeting of the House of Delegates. Dealt with schedule of reference committee meetings to avoid conflicts in time. Referred to the informal committee which is responsible for the appointment and scheduling of reference committees for consideration.

Third "Resolve" *Adopted*
Provided that the attendance records at all sessions of the House of Delegates be published in the IMJ. This was implemented for 1964 and will be continued.

#64-11 and #64-16 Were considered together by the Reference Committee.

#64-11 was *not adopted*, but **#64-16** was *adopted*.

The word "consecutive" was removed from the appropriate portion of the Bylaws and the qualifications for Emeritus Membership were liberalized so that members become Emeritus after "70 years of age and a member for 35 years."

#64-20 Provided for compulsory attendance at county society meetings, in order to maintain membership. It was *not adopted*.

All resolutions which were adopted were referred to the Committee on Constitution and Bylaws, and incorporated in the manuscript of the C. & BL. for 1964-65.

Resolutions Referred to Reference Committee on Legislation and Public Affairs

#64-8, #64-21 and #64-24 Were considered together, and the Reference Committee developed a substitute report containing a substitute resolution which was *adopted by the House* and which authorized: a \$20 voluntary assessment, \$5 for Medical Benevolence and \$15 for Public Affairs, Political Education and Action.

The matter of collecting the \$20 was referred to the Finance Committee by the Board of Trustees and the voluntary contribution was placed on the dues bill for 1965.

#64-12 Regarding "Opposition to 'bricks and mortar' grants" was considered and a *Substitute Resolution was adopted*.

The substitute provided that the "Illinois Delegation to the AMA be urged to continue its opposition to all proposals which might place medicine and medical education under obligation to the United States Government". This was called to the attention of the Chairman of the Illinois Delegation to the AMA for appropriate consideration.

#64-22 Regarding "Blood Bank Activities in Restraint of Trade" *was adopted*.

This resolution supported AMA position in advocating passage of HR 8426; HR 9238 and SB 2560. *A copy was sent to the AMA* as a matter of information and was acknowledged as such.

Resolutions Referred to Reference Committee on Economics and Insurance

#64-6 Regarding "State-wide meetings of county advisory committees to the State Advisory Committee to the Department of Public Aid" required a substitute resolution which *was adopted*.

The substitute provided that "one or more district or regional" meetings be scheduled to provide

the best type medical care possible to recipients of aid. It was *referred to State Advisory Committee for implementation.*

#64-7 Regarding "Obstetrical fees under Public Aid Programs" *was not adopted.*

The Reference Committee commented that "Physicians should re-evaluate the entire program, not just the obstetrical area. Since public aid has continued to expand it has become 'a way of life'. Therefore the question of caring for public aid recipients as 'charity' cases, when public aid is the 'occupation' of that individual, was raised." The fee schedule for the Dept. of Public Aid is now under study by a special sub-committee of the Advisory

Committee and the Fee Schedule Committee.

#64-10 Regarding "Public Aid Policy and Disability Examinations" *was referred to Board of Trustees.*

The Board *determined that* disability claims should be processed within 90 days, or the state would lose federal funds. The Board approved the expediting of the process necessary so that claims can now pass directly from the local physician to state level.

#64-9 Regarding "Medical Society Membership and Hospital Staff Affiliations" *was adopted.*

The House opposed any action which tends to discourage membership in local medical societies, state society and the AMA, especially by inference that reference to membership in county medical societies in the hospital bylaws is unnecessary, undesirable, or illegal. This was *referred to Committee on Hospital Relations* for appropriate consideration.

#64-17 Regarding "Membership on State Advisory Committee to Illinois Department of Public Aid" required a *substitute resolution which was adopted.*

The Board of Trustees has included at least two physicians with a substantial annual patient load of public aid recipients as members of the State Advisory Committee.

#64-18 Regarding "Payment of Realistic Fees for Medical Care of Recipients of Public Aid" *was adopted* and referred to Advisory Committee to the Department of Public Aid, or "appropriate Committee Studying Fees". (See action on resolution #64-7)

#64-19 Regarding "Equal Payment to all Illinois Physicians Rendering Care to Public Aid Recipients" *was adopted as amended.* This was *referred to the Medical Advisory Committee to the Department.* The 1965-67 budget request by the Director includes payment for Chicago physicians. (See report on Advisory Committee)

#64-23 Regarding "Food Allowances for Illinois Department of Public Aid Recipients" *was not adopted.*

Resolutions Referred to the Reference Committee on Publications and Scientific Activities

#64-4 Regarding "Rotating Internships" *was not adopted.* Reference Committee stated that the situation (lack of general practitioners), does not lie in the legislative realm. It *recommended* cooperation with the Illinois Department of Registration and Education, and notification of the Council on Medical Education of the AMA of the desirability and value of 12 months' rotating internship and requested that emphasis on this type of training be exerted at national level. The recommendations were *referred to ISMS Committee on Medical Education.*

#64-13 To "Abolish Scientific Meetings at ISMS Conventions." *No action was taken* because: The Committee on Scientific Assembly and the Committee to Study the Annual Convention have this matter under consideration. The *content of the resolution was called to the attention of both committees.*

#64-15 Suggested a "Department of Forensic Science at the University of Illinois." It was *not adopted* because:

- (1) Forensic Science should be a part of curriculum of ALL medical schools, and
- (2) Use should be made of resources in the Chicago area, together with the possibility of developing further an "Institute of Forensic Pathology" as a part of Cook County Hospital for the use of the entire state.

Resolutions Referred to the Reference Committee on Miscellaneous Business

#64-3 Regarding "Malpractice Defense for ISMS Members." *Not adopted* because the activity is illegal in Illinois.

#64-5 Regarding "Membership in local Chambers of Commerce" required a substitute resolution which was *adopted.* Each county medical society was requested to endorse and support local chambers of commerce.

Follow-up on suggestions of Reference Committees: Administrative Activities

(1) The President-Elect's report asked that all members, county medical societies, and the state society itself, continue to support local, state and national chambers of commerce. Reflecting this suggestion, a Committee to Study the Policy Manual of the Chamber of Commerce of the United States was appointed. See report of Ad Hoc Committee attached as Appendix #1. Members of the Board and staff presented testimony to influence the Chamber to change its statement relative to including physicians under Social Security; Dr. Piszczek, as President, and Mr. Richards, were requested by official Board action to promote the appointment of a physician to the Board of Directors of the Chamber of Commerce of the United States if at all possible.

(2) Another year of excellent relationship and close co-operation with Dr. Yoder and Dr. Visotsky as Directors of the Departments of Public Health and Mental Health has been completed. Their summaries of departmental activities are attached to this report again this year as Appendices #2 and #3. Any supplementary information which either department desires to submit, will be prepared and distributed in the packets at the time of the annual meeting.

(3) Also appended to this report is a statement from the Policy Committee. See Appendix #4. In the packet for distribution to all members of the House will be available the preliminary draft of the Policy Manual, the preparation of which was approved by the House of Delegates in 1963. The Board hopes that this material will develop and that the "handbook" can eventually be distributed to all county medical society officers and committee chairmen to provide them with statements relative to policies established by the House.

Legislation and Public Affairs

(1) The Board of Trustees wishes to call the attention of the 1965 House to a statement in the 1964 reference committee report relative to the development of a museum planned for the Old Capitol Building in Springfield. To quote: "It is the further recommendation of the committee that the ISMS commit itself to raise \$85,000 as its prorated share in restoring the Old Capitol Building, as well as to raise such additional monies as may be necessary for the preparation of permanent exhibits, and that such monies be raised without dues increase to the membership".

The Board has been unable to supply a practical approach to this action, and while it is in complete agreement with the House in desiring to back this worthy project, the problem of raising \$85,000 plus operating expenses, without a dues increase, has not been solved. The Educational and Scientific Foundation has been unable to find any business firm sufficiently interested in medical history to underwrite such activity.

(2) The Committee on Medical Benevolence will have a detailed report for the House. It is with interest that the Board has watched the collection of the \$20 voluntary assessment. In counties where the \$20 was included on the statement form mailed to members, the percentage paying the assessment was high. Where it was not included, but billed separately as a "voluntary assessment" the percentage dropped materially. We expect to have a summary of the results by the time of the meeting and a financial statement from the Benevolence Committee will provide information relative to the success of this project.

Some of our emeritus members have suggested that a letter might be sent to emeritus and retired members of our Society asking that they consider a contribution to the Benevolence Committee, or the payment of the \$20 voluntary assessment. We

agree that some would be able to make the contribution financially. It would be helpful if a policy statement were made by the House of Delegates relative to contacting the dues exempt members for participation in special activities such as those mentioned.

(3) The problem of the enforcement of the Medical Practice Act has been serious this year. Some hospitals have employed physicians to serve as house doctors in emergency services, etc., who are not fully licensed in Illinois. The Board wishes to specifically call to the attention of the House of Delegates that the practice of medicine in Illinois without a license is illegal, and every co-operation should be given to the Department of Registration and Education to enforce the law.

(4) The Committee on Public Affairs has completed its first full year of activity. The Committee is to be congratulated on the state-wide interest it has developed.

Also, along this same vein, the ISMS for the first time, sent physicians to both the Republican and Democratic platform committee meetings and our representatives appeared to testify on behalf of the membership. Courteous hearings were granted by both parties; excellent testimony was prepared and presented. Copies of either or both are available for anyone desiring to read the material presented on behalf of the membership.

Economics and Insurance

(1) The area in which this division works draws more comment from the membership as progress continues in various projects. The Illinois Department of Public Aid and its program for the care of recipients of assistance has been subject to study by the Board to provide co-operation and development for various complicated phases of activity.

For this reason, and because of the various controversial subjects with which the program deals, the Board encouraged a half day program at this annual meeting to assist members of the House to discuss and to become familiar with all the ramifications in the programs.

(2) This division has developed (under the Keogh Bill) the retirement investment program for the members of the Society. Before the close of 1964 members of ISMS were able to participate either in annuity programs or a no-load mutual investment fund. The Board was informed of all activity and the committee report will present the important details for the House consideration and action.

Public Relations

(1) The Board has been most interested in various activities of this division. Some of the projects such as Medical Self Help Training, Disaster Manual for Hospitals, Grievance Committee work, Physicians' Placement Service, Community Health Week promotion, etc. continues to interest and concern the members of the Board.

(2) The Public Relations activities necessary in its informational campaign on Medicare and Elder-care which was authorized by the special meeting of the House of Delegates, has had the close and continued supervision of the Board. A supplementary report will be given by the Board of Trustees on this campaign at the time of the meeting.

The financial aspects of the informational campaign were mailed to all members of the House and all officers of county medical societies following the special meeting. The expenditure of over \$200,000 in such a campaign necessitates the close co-operation and supervision of the Board, and demands the concern and interest of all members. As chairman of the Board of Trustees, I would make a special request that every member of the House concern himself personally with the material to be published, and take back to the membership of his society a detailed and accurate account of the services being provided members under this program financed by the first special dues assessment in the history of the Illinois State Medical Society.

Publications and Scientific Activities

The effort to develop a joint meeting with the Chicago Medical Society at the time of their Clinical Conference, and perhaps with the American Medical Association in years when Chicago is the host city, is still before the Board. It presents many and varied problems, none of which is easily solved. For the present they remain under study.

The Institute of Forensic Pathology will be watched with interest as it develops and fills a more important role in this vital field of medicine. The Board is aware of existing conditions and the resources of the State of Illinois are being extended and are available for the use of members of the profession.

Miscellaneous Business

The Board has watched with interest, the development of the Illinois Association of Professions, and would like to call the attention of the House to the fact that the organization is complete, the first annual dinner has been held, and new officers have been elected for the second year of activity. The services this group can provide will be of vital importance during coming years, and the work the various professions can accomplish as a unit may contribute materially to the maintenance of basic freedoms.

Activities of the Board in Other Fields

(1) For the first time a foreign physician was the guest of the Illinois States Medical Society, Dr. Joseph Farber, Brussels, Belgium, an officer in one of the two Belgian Medical Associations, appeared before the Board, the House of Delegates, on radio, television, and for press conferences to report in detail on the "strike" of the Belgian physicians against the socialization of the medical profession in his nation.

(2) In September, Dr. Harlan English appeared before the Board and outlined the survey being made of the future needs in the field of medicine in the State of Illinois. The survey is being conducted under a grant from the Commonwealth Fund by Lester J. Evans, M.D., under the auspices of the University of Illinois. The basic recommendations made by Dr. English at the close of his presentation included:

(1) the use of existing and planned junior colleges for the first two years of college work; (2) the use of the University of Illinois Urbana campus for the last two years of university training and the first two years of medicine; (3) the use of Research and Educational Hospitals for the third and fourth years of medical training; (4) the activation of "Unit 2" of the University of Illinois by the way of old Rush, Presbyterian-St. Luke's and Cook County Hospitals for the other third and fourth year center of medical training, and (5) the use of 4,000 beds in 10 designated towns in Illinois for residency training as affiliates of Unit 1 or 2 of the University.

Dr. English also projected the type of physician who would be in demand at the end of the next 10 years. Of the 462 general practitioners who will have to be replaced—only 20% will be general practitioners. The other 360 will be replaced by specialists—94 obstetricians; 90 pediatricians; 327 internists, and 40 psychiatrists according to the present predictions.

While this will affect the present physician little, it will affect his sons and daughters who might enter the practice of medicine. The Board, with the assistance of men such as Dr. Evans, will try to keep abreast of the times, find a way to help keep the medical schools in Illinois at the head of the list; work to maintain the physician-population ratio and work to provide the medical personnel for areas where they are needed. The southern part of the state is faced with a shortage, and the solution is under consideration.

(3) Our legal counsel has provided us with several interesting opinions during the past year. The first had to do with a warning that physicians should NOT fill out questionnaires (automobile insurance forms) in which they were asked to state or to give opinions as to whether or not any "nervous disease" existed or might appear, within the next twelve months.

Another opinion concerned the testing for blood alcohol and physician liability. Our attorney stated that he does not believe that physicians in Illinois can draw blood for the purpose of an alcoholic test without liability being placed upon the physician involved. The taking of blood from an individual is an act which cannot be done legally without his implied or specific consent, with an emergency as the only exception. These opinions were sent to all county medical society secretaries.

(4) The Mayor of Chicago's Commission on Senior Citizens plans awards for 1965 and suggestions

were requested for a candidate from the Illinois State Medical Society. Dr. George F. Lull was so honored last year. For the 1965 award, the name of Dr. Warren H. Cole, Professor and Head of the Department of Surgery at the University of Illinois College of Medicine, was selected, and the material will be prepared and presented.

(5) Dr. Carl D. Dauer, Medical Advisor to the Department of Health, Education and Welfare, spent June 30 in the headquarters office. He discussed the survey of selected Illinois counties approved by the Board as a part of the collection of information on the nation's health. The survey now being made is of children's health in 40 areas in the United States. About 8,000 children (6 to 11) will be examined. Factors to be considered are growth and development, and brief reports of the medical and dental files will be sent to the family physician and dentist upon the parent's request. Counties involved are Cook, Lake, McHenry, Kane, DuPage and Will. As far as we are able to determine each of these counties is co-operating.

(6) In January, 1965, the Mayor of Chicago invited officers of ISMS to attend the Chicago Board of Health luncheon at which Michael E. DeBakey, M.D., chairman of the President's Commission on Heart Disease, Cancer and Stroke, was the speaker. Dr. Fishbein (Heart Association), Dr. Roger Harvey (Stroke) and Dr. Portes (Cancer) were invited to be representatives of the three groups. The Board felt "that due to duplication of facilities, costs and services rendered, the proponents of the President's Commission on Heart Disease, Cancer and Stroke, do not necessarily express the feelings of the ISMS." Dr. Piszczek, as president of the Society, appointed a group of three to meet with the physicians involved in the Chicago Board of Health, prior to the luncheon, to express to them this feeling of the Board of Trustees. The committee was composed of Drs. Philip Thomsen as chairman, Frank J. Jirka and Caesar Portes. The DeBakey proposals are currently under consideration by the U. S. Congress. The AMA has presented testimony and our committee may present additional information at the time of the meeting.

(7) The Health Improvement Association plans a series of nine conferences during the spring of 1965. The subject will be the "Utilization of Insurance for Hospital Care." The ISMS was asked to co-sponsor the meetings with the Illinois Hospital Association. The Health Improvement Association has some 80,000 members composed primarily of farm families securing their Blue Cross-Blue Shield coverage through the Health Improvement Association. Any physician appearing on these programs before these groups should be well informed. The Board recognized the importance not only of the group, but also of the subject, and therefore agreed to act as co-sponsor. Delegates in the House from downstate areas where these meetings are held, should be aware of the importance of the program and the organization involved.

Innumerable items came before the Executive Committee during the year. They were referred in writing to the full Board of Trustees for consideration and action. Only a very few of these subjects were not part of the planned activity of the many efficient and well-organized committees which are serving your society and report to the Board of Trustees.

As the work of staff, and the organization of the headquarters office to serve the committees, trustees and officers of the society, grows, there are fewer items unassigned to committees for implementation. Therefore, the chairman of the Board desires in every way possible, to avoid the duplication of reporting to the House, and wants to take this opportunity to call the attention of the delegates to the development which has taken place in the past five years. The Illinois State Medical Society, as the fourth largest society in the United States, is taking its place among the leaders in the scientific, economic, legislative, public relations and administrative fields of organized medicine.

This growth and development is the result of adequate staff, devotion of the officers and trustees to work assigned, and the gradual extension of the lines of communication from the headquarters and regional office to the individual members throughout the state.

In addition to my duties as Chairman of the Board of Trustees, I serve as Trustee of the Third Trustee District. In my role as Chairman of the Board I have attended all board meetings, meetings of the AMA, special Executive Committee meetings regarding important activities of the Society, including the Legislative and Public Affairs Conference, and numerous conferences with the Executive Administrator in order to continually evaluate the progress of the Society.

I wish to extend my personal appreciation to my fellow officers, Trustees, and staff members for their support during this past year.

William E. Adams, *Chairman*

APPENDIX #1

COMMITTEE TO STUDY THE POLICY OF THE CHAMBER OF COMMERCE OF THE UNITED STATES S-2

This Committee was established especially for the purpose of reviewing current policies of the Chamber of Commerce of the United States which reflect themselves in matters dealing with medical affairs. In our review of the policies we found the Chamber to very adequately express itself in support of the private practice of medicine in its section having to do with health and medical care. I should like to quote the following portions as found in the Policy Declarations of the Chamber of Commerce of the United States:

"Community Health Activities. Efforts to improve the nation's health should center at the community level. Accordingly, we urge local businessmen to help initiate and support sound community health activities.

"Medical Care. Legislation designed to supplement voluntary welfare efforts in financing medical care for those unable to provide it for themselves, regardless of age, should preserve the principles of local participation and determination.

"Public Health Activities. Environmental sanitation, communicable disease control, health education, and many other activities constitute the accepted programs of state and local health departments. The federal government should be concerned only with public health problems that are national in scope and character.

"Voluntary Health Insurance. Development of voluntary health insurance should be encouraged. "Sound voluntary health insurance plans recognize that nominal and recurring losses are better financed as a part of the family budget than through insurance, and insure against larger, financially crippling losses. Plans providing that the insured bear a fractional part of each loss guard against over-utilization of health care facilities and tend to prevent higher costs for health coverage.

"Employers are encouraged to facilitate access to appropriate voluntary group plans as an aid to employees in meeting their health needs, effectively and economically, both during employment and in retirement.

"Legislation for compulsory medical and hospital insurance should not be enacted. Federal encroachments and controls in the field of health insurance should be opposed.

"Veterans' Benefits. The national obligation to provide adequate care and compensation for service-incurred disability is no justification for special protection of veterans for other than service-incurred disability."

In a review of the policies of the Chamber regarding the federal social security program, we found that its policies were as follows:

"Coverage Extension. Extension of the old-age, survivors' and disability system (OASDI) should be made promptly to noncovered categories.

"Social Taxes. The OASDI system should continue to be supported by equal taxes on employers and employees and by taxes on the self-employed periodically adjusted to support benefit disbursements on as current a basis as practicable."

We concluded that these policies in fact endorsed the inclusion of physicians under the Social Security program. (OASDI). Therefore, with the approval of the Board of Trustees, we sought an audience with the Committee on Economic Security of the Chamber in co-operation with representatives of the Oklahoma State Medical Society, the

Texas Medical Association, and the AMA. We presented lengthy testimony to support our request for a change in this policy to the effect of excluding physicians under the social security system.

The Committee on Economic Security at its meeting on Feb. 4-5, 1965, tabled a recommendation to change the policy. On Feb. 16, 1965, our Committee requested an audience with the Policy Committee of the Chamber. On Mar. 1, 1965, the chairman of your committee, with representatives of the Oklahoma State Medical Society, the Texas Medical Association and the American Medical Association, repeated the same testimony presented to the Committee on Economic Security. We were favorably received, and based upon the discussions while we were present in the room it would appear that a change in policy will be recommended. The Policy Committee of the Chamber also sought our recommendations with respect to the exact wording which may be utilized. Several alternatives were suggested with which the representatives of organized medicine agreed. It is possible that by the time our House of Delegates meets we will know what the Chamber policy recommendations will be to the National Chamber meeting which takes place the week of Apr. 26, 1965.

Edward A. Piszczek, *Chairman*
Newton DuPuy B. E. Montgomery

APPENDIX #2

ILLINOIS DEPARTMENT OF PUBLIC HEALTH S-3

In the science of preventing diseases and promoting health for all its citizens, Illinois has an excellent record. This has been made possible through a great many circumstances. Not the least of these is the cooperation and collaboration of the private physicians and the allied health professions.

The good health of the people is the very substance of the state's vitality, strength and progress . . . and an effective health service must be keyed to the needs of the people, using knowledge of past and present occurrences to forecast future needs.

It has become a tremendous undertaking to keep pace with the vast reaches of the sciences and activities that impinge on the public health.

Some of the major functions of the Department are summarized in the following pages, describing what it is planning and performing in public health.

The Department requires that all births, deaths, and certain communicable diseases must be reported. From statistical studies, much knowledge is gained of the state of the public health.

In 1964, the state population was 10,500,000. The

birth rate remained about the same as in the previous year, with the deaths down slightly.

The steady lowering of the number of deaths at the early ages has forced the concentration of deaths among the older ages and especially among those afflicted with chronic illnesses. Leukemia, accidents, pneumonia and influenza have come into prominence among young persons. At the present time, persons in the middle-age groups appear to be more subject to heart and respiratory diseases, cancer, diabetes and cirrhosis of the liver. There is evidence that the cardiovascular-renal diseases can be controlled, except at the oldest ages.

Accidents and other forms of violence are the principal causes of loss of life in the 15 to 24 age group.

PREVENTIVE MEDICINE ACTIVITIES

The continuing rise in gonorrhea and infectious syphilis cases—particularly in young people—has spurred preventive measures. Epidemiological follow-up and educational programs have been intensified as has educational efforts.

The U.S. Public Health Service cooperates by providing highly trained public health advisors. Three have been assigned to the Department on an indefinite loan basis. They will participate in a private physician visitation program to solicit their help in the control of venereal disease. During 1964, 932 private physicians were visited.

In operating a new front in the attack on venereal disease, sex education for young people has been given greater emphasis. Numerous programs were presented to schools, PTA's, and civic groups during the year by the advisors. The Department was a cooperating agency in two statewide sex education and venereal disease workshops held for key people involved in the total situation: one held in Springfield and one in Chicago.

A written account of one of these workshops appeared in the "Illinois Health Messenger" and aroused such demand for copies that a reprint had to be made to fill requests.

Sex Education Pamphlets

On the basis of interest shown, the Department obtained copies of the new pamphlet for parents of young children, "Beginnings in Sex Education" for distribution throughout the state. In another public relations effort, interest was aroused in an editor of a Springfield newspaper which resulted in a series of six articles and an editorial on the total situation, plus aroused interest in several large civic groups. This interest in the need for sex education is continuing.

Infectious syphilis cases (primary, secondary and early latent) reported for 1964 in the age group 15-34 totaled 1,595 in Illinois. Total number of infectious syphilis cases reported was 2,190 last year.

Gonorrhea cases reported in the 15-34 age group totaled 22,045 last year. Total number of cases in all age groups was 26,866.

Disease Rises Downstate

While the majority of venereal disease cases are reported from Chicago, cases are increasingly reported from downstate. These statistics reveal a rise from the previous year and also the age groups mainly involved. It is estimated by public health officials that less than half of the actual cases are reflected in the reported incidence of these infectious venereal diseases. One aspect of the physician-visitation program is to encourage the private physician to report all cases of venereal disease known to him, and to offer health department services to him, including drugs and consultative services. It is in finding and treating contacts of known cases that the spread of the disease is lessened. This type of follow-up is provided by the Department.

The Department's program continues to expand in the administration of the Illinois Uniform Hazardous Substances Labeling Act and prevention and control of accidental poisoning in children. Poison control centers in hospitals in the state now number 92, which operate on a 24 hour daily basis. Centers are supplied with up-to-date reference cards and other information on toxicity of poisonous substances. It is estimated that about 22,000 children were treated for accidental poisoning last year in hospitals, although only about 12,700 cases were reported from the centers or the other 80 hospitals voluntarily reporting. Accidental poisoning in children continues to be a serious health problem. A First Aid Chart for accidental poisoning was developed and distributed for lay use. This ready reference in emergencies has been in great demand.

Sight and Hearing Activities

A hearing conservation coordinator was added to the school health program and a three-week workshop was held for nurses working in school health. The Department has assisted local agencies to provide vision screening to children in several communities. Plans for several demonstration projects are under way. Helping to coordinate and plan school screening programs concerning vision and hearing is one of the functions of this unit.

In cooperation with the Mental Health Department, the Department is carrying on a cooperative study of needs of the mentally retarded who are on waiting lists for admission to state schools. This includes community resources as well as resources needed in the home to assist families in caring for such persons at home. The survey is expected to produce other valuable data necessary for overall planning activities for the mentally retarded.

The program for the detection and treatment of phenylketonuria includes research, diagnostic and screening tests, laboratory service, provision of dietary assistance to those eligible, medical supervision, a central registry for the state, cooperation with the Mental Health Department, and long term

follow-up of susceptible families. At the end of 1964, 58 phenylketonuric children were receiving services of this nature.

Department laboratories performed thousands of tests for PKU on specimens from newborns in a new phase of this program.

Program for Prematurely-born

In the Department's program for specialized care for the prematurely-born infants, 1,596 infants were cared for in the six centers, up 74 from the number cared for during 1963.

Due to the reported high incidence of measles in the state, the Department purchased a limited amount of live virus measles vaccine and made it available for immunization programs in local health departments. Biologicals distributed by the Department include those for the prevention of whooping cough, typhoid, diphtheria, tetanus, and smallpox. Upon a physician's request, the Department also supplies vaccinia immune globulin and gamma globulin. In prevention of recurring attacks of rheumatic fever, prophylactics are distributed to those eligible for this care. Pasteur treatments (antirabies vaccine) are also provided by the Department upon request.

A new four-year Illinois-Cornell Automotive Crash Injury Research program has been approved by the various participating state agencies, with the Department serving as the medical coordinating unit.

4 Die of Encephalitis

The outbreak of mosquito-borne encephalitis in the latter part of 1964 was the first of its kind in Illinois since the early 1930's. By the time it was over, there were 48 confirmed cases of St. Louis type encephalitis and two cases of Western equine encephalitis, resulting in four reported deaths.

This emergency situation was distinctive for the complete and immediate cooperation given the Department by the U. S. Communicable Disease Center, state and federal departments of agriculture, state and federal departments of conservation, the Zoonoses Research Center at the University of Illinois, local health departments, hospitals and physicians. Many disciplines were involved in attempting to limit and control the outbreak.

There was a concurrent outbreak of mosquito-borne encephalitis in horses throughout the state. Close cooperation was again notably demonstrated by the various agencies and groups involved in control and treatment. In all, there were 263 cases of Western equine encephalitis in horses resulting in 57 deaths.

Delineating the exact means by which animal diseases are transmitted to man and the controls which must be established to prevent such transmission is a major part of the Department's veterinary public health program. This goal requires close cooperation with other agencies such as the state departments of Agriculture and Conservation, University of Illinois College of Veterinary Medi-

cine, the Center for Zoonoses Research and the practicing veterinarians in the state.

During 1964, the primary areas of cooperation were rabies, leptospirosis and arthropod-borne encephalitis, with a great deal of cooperation in the areas of insecticides, trichinosis and brucellosis.

Rabies Increases 40%

Because of the increase in rabies in Illinois in the past year (238 animal cases, a 40 percent increase over 1963), a stepped-up program in control measures has been launched. Because of the known great reservoir of rabies in skunks, the state program will be started in selected sections where there have been proven skunk rabies cases. Teams visiting these areas in the skunk reduction program will consist of personnel from the State Public Health Department, State Agriculture Department and the U. S. Fish and Wildlife Service.

Last year, exposed persons who had to take the painful antirabies vaccine exceeded 800 in Illinois.

Rabies prophylaxis in man has long been a special problem when it involves particular high risk groups of individuals, such as field naturalists, dog handlers, laboratory workers and, especially veterinarians. In these groups, repeated exposure meant repeated treatment, thus increasing the possibilities of severe reactions to the vaccine, particularly those involving the central nervous system.

It has been found that a single injection of any potent antirabies vaccine given to an individual who had had antirabies treatment in the past resulted in a prompt and significant antibody rise. For the past few years it has been recommended that in the case of mold exposure of an individual who has demonstrated an antibody response to antirabies vaccination received in the past, a single booster dose of vaccine be given.

Rabies Gamma Globulin Project

Practically no veterinarian escapes taking the complete primary antirabies treatment, and formerly had to take many post-exposure treatments. Today's veterinary graduates usually have had pre-exposure vaccination. Because of this, veterinarians throughout the country are being asked to donate blood to the U. S. Communicable Disease Center for use in a rabies gammaglobulin project.

After research and development, it is hoped that a potent and safe biological product for use in treatment of exposures to rabid animals will then be made available for distribution on an emergency basis. The ultimate aim is to eliminate shock syndrome and "delayed serum sickness" occurring in some persons after antirabies treatment.

The Department's veterinary section is cooperating fully with this project to the extent that Illinois is presently top ranking in the country in the number of volunteers.

LABORATORY SERVICES

Through its laboratories located in Springfield, Chicago, Champaign, Carbondale, East St. Louis

and Rock Island, the Department brings diagnostic and sanitary bacteriology laboratory services within easy reach of every section of the state.

During the fiscal year ending June 30, 1964, about 34,000 laboratory tests for virus infections were performed. Some of these were done in a study on the role of virus infections on acute heart diseases.

New Tests for Syphilis

A new laboratory service was the introduction of the fluorescent treponemal antibody tests for syphilis. This test is used primarily in an attempt to rule out falsely positive findings in the standard-routine tests for syphilis. The fluorescent antibody test was adopted as routine procedure for the diagnosis of rabies after a two-year period of evaluation. The test supplants the slower mouse inoculation procedure except in a few special instances.

The number of *Salmonella* cultures identified as to species in the laboratories totaled 1,628, with most of these implicated in food-borne infections.

All laboratories and blood banks in the state were registered as required by a new law. Most of these have been inspected and all of them have been invited to participate in the laboratory approval plan. In connection with the latter plan, 15,000 syphilitic and normal blood specimens were prepared and shipped to the 620 clinical laboratories under test for initial or continued approval of their work. During the year about 5,000 blood cell suspensions were sent to laboratories to check on the accuracy of the tests used in connection with blood transfusions and an additional 4,600 check specimens containing tubercle bacilli and related organisms were also supplied to laboratories to test their competence in this field of work.

The toxicology laboratory, operating on a 24-hour basis, studied material from 268 cases of various kinds.

Number of Tests Increases

Laboratory tests for fungus infections revealed that of the 1,603 tests performed for histoplasmosis, 255 were positive; of the 613 tests for blastomycosis, 59 were positive, and two of the 619 tests for coccidioidomycosis were positive.

The total number of tests done in connection with the protection of water, dairy products and air amounted to about 250,000, an increase of 8.4 percent from the previous fiscal year record.

Other activities include a reference service which permits other laboratories to submit any problem specimens which they are unable to diagnose completely.

Technical advances have greatly extended the capabilities of laboratory workers. Training programs and seminars are held, both in the field and in state laboratories, to acquaint local laboratory workers with new or improved methods.

ENVIRONMENTAL HEALTH SERVICES

An important part of the Department's activities is the administration of laws pertaining to the control of environmental factors affecting the public health. Following in the wake of man's technological progress are many health hazards. Conserving water, controlling pollution of both air and water are mandatory for good health. The bacteriological safety of 1,478 public water supplies is the responsibility of the Department. The 1,275 public swimming pools in the state are also periodically inspected and approved by the Department.

Almost 500 trailer parks were inspected and licensed during 1964 by the Department, as well as about 140 agricultural migrant labor camps.

Engineers performed a survey of the waste-disposal efficiency of lagoons on hog farms, part of the procedure of the new method of raising hogs by confinement feeding similar to the caged production of chickens. Criteria was developed for selection of site, size and sanitary specifications.

Abatement of stream pollution, insect and rodent control all come within Department jurisdiction. Many educational and training programs are carried on by the Department to improve the competency and skills of persons engaged in various occupations concerning environmental health.

The Air Pollution Control Board was organized and began development of an interstate compact with the state of Indiana. Plans were made and space obtained for an air pollution laboratory in Springfield.

A central registry has been established by the Department for maintaining records of reported radiation exposure to persons employed in the radiation field. Criteria was developed for selection of a site for disposal of radioactive wastes. Radiation installations in the state are registered and inspected by the Department, from x-ray machines to nuclear reactors. Nuclear fallout monitoring stations are situated in three different locations in the state and a continuous radiation surveillance check is kept on Illinois waters.

CHRONIC ILLNESS

For about 40 years, heart disease has been the top killer in Illinois. It also causes more chronic disability than any other disease entity.

Most of the heart programs of the Department are slanted toward primary prevention. Efforts are made to inform the public concerning the dangers of recurring attacks of rheumatic fever. The Department encourages and helps finance throat culturing projects in various parts of the state in efforts to discover the causative organism of rheumatic fever, Group A, *beta hemolytic streptococcus*, to prevent the possibility of rheumatic fever.

The Department actively encourages and helps finance early diagnosis and treatment in cancer detection and diabetes-detecting clinics on local levels.

HOSPITALS AND NURSING HOMES

Under the Hospital Licensing Program, about 300 hospitals are inspected and licensed each year. Maternity hospitals are given special attention by the Department.

To determine that a proposal for any new hospital is sound and in the public interest, all proposals are evaluated before they are approved for architectural planning. The Department also administers the Federal Hospital Construction Program (Hill-Burton) in Illinois, whereby communities are given construction grants to assist them in acquiring needed medical facilities.

Nursing homes, sheltered care homes and homes for the aged are also inspected and licensed by the Department. During 1964, a total of 133 licenses were issued for new facilities in these types of homes, and 876 renewals for existing homes. Educational projects for personnel of these homes are sponsored by the Department in efforts to improve nutrition and care of the residents.

Attempts to make victims of chronic disease and the aged more useful and independent are of increasing concern to the Department. Outside of hospitals, the chronically ill receive considerable help and guidance from public health nurses. All phases of nursing care service in the home have been expanded.

TUBERCULOSIS CONTROL

Early in 1964, a family-centered tuberculosis case finding program was planned and put into operation in 15 southern Illinois counties. The study centered around the tuberculin testing of children in the first, fifth and ninth grades, followed by an intensive search for tuberculosis among the household associates of those children who were infected with the tubercle bacillus. As a part of the program, all teachers and other school employees are periodically tested. This program, added to the existing case finding and case holding procedures, will hopefully reduce the tuberculosis morbidity in this endemic area.

Following the U. S. Public Health Service recommendations, the Department will concentrate on a family approach to case finding through children, as in the southern Illinois Project. The use of the mobile chest x-ray unit in indiscriminate search for tuberculosis has been discontinued.

The Department has made available for use in specific case finding projects three hypospray jet injectors and the personnel to operate them. In addition, tuberculin test materials for individual use in local health departments and physicians' offices is also supplied by the Department.

The Chicago State Tuberculosis Sanitarium continues its arrangement with the Department of Mental Health in performing all thoracic surgery required by patients in the various institutions under jurisdiction of the Mental Health Department. The Mt. Vernon State Tuberculosis Sanitarium, in

conjunction with the local school system, continues its school for practical nursing.

DENTAL HEALTH

The Department promotes and encourages the fluoridation of public water supplies. In Illinois, about five and one-half million people are drinking water with added fluorides and another one-half million are drinking water that has enough natural fluorides in it to provide dental benefits.

An extern program in which four graduates receive on-the-job training experience in public health each summer has been one of the Department's activities for the past two years.

During 1964, 20,000 school children were given dental examinations by the Department in a project designed to reveal the extent of dental disease among children in the state.

New educational aids for use by schools and also civic groups have been developed by the Department to promote better dental health and in understanding how this relates to the total health.

The Department continued its mandated program for animal disease control, improved milk harvesting methods, and new processing safeguards.

The Grade A. Milk Law and the Milk Pasteurization Law were supplemented during 1964 by the Bulk Milk Tank Operators Licensing Act. More than 1,000 examinations were held pursuant to the Licensing Act to assure that operators of bulk milk tanks had the necessary knowledge and were operating their tanks in a safe sanitary manner.

Insofar as the safety and quality of the fluid milk supply is concerned, the state has an enviable record. There has not been a single milk-borne disease epidemic traceable to Illinois milk supplies in the past 20 years.

In its everyday function and long range planning, the goal of the Department is to attain and maintain the highest possible standard of health for the people that it serves.

Franklin D. Yoder, *Director of Public Health*

APPENDIX #3

DEPARTMENT OF MENTAL HEALTH S-4

During the 12-month period between April, 1964, and April, 1965, the Department of Mental Health has made steady progress toward its long range goals:

1. Return comprehensive mental health services to the community by enlisting community support, skills and talents in providing brief, intensive treatment at the first stage of illness.

2. As far as possible, keep patients in their communities and from the very beginning of treatment prepare them to resume productive roles in their community.

3. Prevent mental illness by establishing cooperative programs with all community agencies—welfare, educational, law enforcement, governmental, religious and others—through education, early case finding and prompt referral.

Reaching These Goals

Using this public health model, the Department has undertaken three broad programs to accelerate its progress in reaching its goals:

Department Reorganization: On Jan. 1, 1964, when the Department of Children and Family Services became a code department, the Department of Mental Health for the first time in Illinois history became devoted solely to treatment of emotional and mental illness as well as mental retardation. This open the way for internal reorganization. Today there are eight divisions each providing valuable and rapid consultant services to the directors of the Department's zone programs.

To recruit staff for these programs increased salaries now enable Illinois to compete with other states for valuable professional staff. Flexible hiring procedures permit the Department to hire capable, creative staff people at salaries commensurate with their background, training and experience. Meanwhile, some of the personnel in service at the present time are being given intensive training to broaden their understanding of the mentally ill with whom they work.

The Zone Mental Health Program: To give meaning to the state's zone or regional mental health concept, in 1961 the state was divided into eight zones. In each zone a director will work with a state facilities and community groups within his multi-county zone in developing a mental health program that best serves the needs of his region. The Department's eight divisions will assist him in recruitment, administration, program development and other specialized areas.

The focal point of these regional programs will be the zone centers now under construction. The first center—Charles F. Read Zone Center, Chicago—will open this spring. All of the others will be completed and operating by March, 1967. In five of the eight zones, directors have been named. The directors are presently planning treatment programs and recruiting staff so that as their center is completed they will be able to move in and begin their program immediately.

The zone centers themselves will be the most modern in architectural design and among the first facilities in the nation to reflect advanced intensive treatment programs. The programs are not centered on in-patient treatment, although each center has between 170 and 280 beds. Rather, they will emphasize programs on prevention and rehabilitation in the community and, wherever possible, will concentrate on brief intensive out-patient treatment at the center.

Since all of the centers will become operational during the 74th Biennium (1965-1967), a \$56,816,-

594 increase in Department general revenue appropriations is being sought to continue present programs and provide additional staff at the state hospitals and some 2,785 employees at the zone centers.

The State Hospitals—Other Zone Centers: Equally important to the zone center program is the endeavor to convert the existing state hospitals into other zone centers or units serving their nearby communities. Much has been done already to rehabilitate the hospitals' physical plants, reduce overcrowding, increase staff, initiate new training and treatment programs. The treatment programs focus on out-patient services thereby changing the state hospitals into community oriented operations which will complement programs at the new zone centers.

Since the end of World War II, population growth and community expansion have grown out and around most of the state hospitals. Today the only thing that can keep the hospital isolated from its communities is a custodial program. Because the people of Illinois are looking to both present facilities and the new ones now under construction for imaginative new programs, the Department is emphasizing intensive treatment at its present facilities as well as in the new centers. Program excellence must be backed by additional funds for increased staff if this long sought goal is to be reached—a goal which in the long run will be more economical to the taxpayer.

The bond issue construction program, largest in the state's mental health history, is well past the halfway mark. As of the beginning of 1965, of 70 major building projects at the state hospitals, 25 were completed; 11 were 90 to 99% complete; 15 were 70 to 90% complete; seven between 50 to 70%; the remaining 12 are less than 50% complete. These represent nearly \$100 million in projects.

The Zones in Brief

ZONE I: Norris Hansell, M.D., Zone Director—
Office: State of Illinois Bldg., Chicago

The H. Douglas Singer Zone Center,
4402 Main St., Rockford.

Comprehensive Mental Health Services

1. Out-patient Department

2. In-patient Department—220 beds

Projected number of employees:

481 for Zone Center;

20 Rockford Zone Administration Office

ZONE II: Arthur Woloshin, M.D., Zone Director—
Office: Rm. 732, 2400 Madison St., Chicago

The Charles F. Read Zone Center,

4200 Oak Park Ave., Chicago.

Comprehensive Mental Health Services

1. Out-patient Department

2. In-patient Department—278 beds

Projected number of employees in 74th

biennial budget:

536 in Zone Center;

13 in Zone Administration Office.

Institutions:

Chicago State Hospital,
6500 W. Irving Park Road.
Elgin State Hospital, Elgin.

ZONE III: Bernard Rubin, M.D., Zone Director—

Office: State of Illinois Bldg., Chicago

The John J. Madden Zone Center,
Roosevelt and First Sts., Hines.

Comprehensive Mental Health Services

1. Out-patient Department
2. In-patient Department—278 beds

Projected number of employees

74th biennial budget:

362 in Zone Center;

11 in Zone Administration Office.

Institutions:

Manteno State Hospital, Manteno.
Tinley Park State Hospital, Tinley Park.
Medical Center Complex, Medical Center
District, Chicago.

Institute for Juvenile Research,

907 S. Wolcott St., Chicago.

Illinois State Pediatric Institute,

1640 W. Roosevelt Road, Chicago.

Illinois State Psychiatric Institute,

1601 W. Taylor St., Chicago.

Mental Health Center,

2449 W. Washington Blvd., Chicago.

Warren Clinic for Alcoholics

ZONE IV: Thomas T. Tourlentes, M.D.,

*Zone Director—Office: Galesburg State
Research Hospital*

The George A. Zeller Zone Center,
5327 N. University, Peoria.

Comprehensive Mental Health Services

1. Out-patient Department
2. In-patient Department—220 beds

Projected number of employees:

368 in Peoria Zone Center;

15 Peoria Zone Administration Office.

Institutions:

East Moline State Hospital, East Moline.

Galesburg State Research Hospital,

Galesburg.

Peoria State Hospital, Peoria.

ZONE V:

(Zone Director not appointed at this time.)

The Andrew McFarland Zone Center,
Springfield.

Comprehensive Mental Health Services

1. Out-patient Department
2. In-patient Department—172 beds

Projected number of employees:

472 in Zone Center;

6 in Zone Administration Office.

Institutions:

Jacksonville State Hospital, Jacksonville.

ZONE VI:

(Zone Director not appointed at this time.)

The Adolf Meyer Zone Center, Decatur.

Comprehensive Mental Health Services for
Adults

1. Out-patient Department
2. In-patient Department—224 beds

Projected number of employees:

322 in Decatur Zone Center;

6 in Decatur Zone Administration Office.

The Herman M. Adler Zone Center,
So. First St., Champaign.

Comprehensive Mental Health Services
(including research in collaboration with
University of Illinois) for children

1. Out-patient Department
2. In-patient Department—60 beds

Projected number of employees:

184 in Zone Center

Institutions:

Kankakee State Hospital, Kankakee.

ZONE VII:

*(Zone Director not appointed at this time.
East St. Louis designated by organization
chart as "Headquarters City")*

Institutions:

Alton State Hospital, Alton.

ZONE VIII: Robert C. Steck, M.D., Zone Director

—Office: Anna State Hospital, Anna

Institutions:

Anna State Hospital, Anna.

Illinois Security Hospital, Menard.

Mental Retardation

The zone for mental retardation services is considered to include the entire state with headquarters in Springfield under the direction of William Sloan, Ph.D., Division of Mental Retardation Services.

Residential Centers for the Mentally Retarded

The A. L. Bowen Children's Center, Harrisburg.

Comprehensive Services for the
Mentally Retarded

1. Out-patient Department
2. Research Department
3. In-patient Department: 256 beds

Projected number of employees: 329

Dixon State School, Dixon.

Residence, School, and
Hospital for Mentally Retarded

1. Patient Population: 4,779
2. Number of Employees: 1,371

Lincoln State School, Lincoln.

Residence, School, and
Hospital for Mentally Retarded

1. Patient Population: 4,930
2. Number of Employees: 1,476

The Warren G. Murray Children's Center,
Centralia.

Out-patient and In-patient Services for
Mentally Retarded

1. Patient Population: 205
as of December, 1964

2. Number of Beds:	728
3. Number of Employees:	452

Each of the new zone centers now under construction will provide facilities and programs for the mentally retarded.

Federal Research and Training Projects

Anna State Hospital: 1) \$300,000 Hospital Improvement Project Grant for three years to establish a 7-day program in activity therapy. 2) As of December, 1964, 166 people had enrolled under the Area Redevelopment Act for psychiatric aide training. Fifty-nine have already graduated; of these, 29 have been employed by the Department of Mental Health.

Chicago State Hospital: As of December, 1964, 213 people had enrolled for housekeeping services training under the Manpower Training Act. One hundred and forty-seven have graduated; of these, 66 have been employed by the Department of Mental Health, and another 56 have been employed by private hospitals.

Galesburg State Research Hospital: 1) \$154,000 Health Research Facilities Grant to enlarge facilities of its Thudichum Psychiatric Research Laboratory. 2) \$150,000 U.S. Public Health Service Training Grant for three years to expand General Practitioner Residency Training Program. 3) As of December, 1964, 173 people had enrolled under the Federal Manpower Training Act for psychiatric aide training. One hundred and twenty-nine have graduated; of these, 118 were subsequently employed.

Jacksonville State Hospital: \$125,000 National Institute for Mental Health In-Service Training Grant to intensify training of psychiatric aides.

Kankakee State Hospital: \$125,000 NIMH In-Service Training Grant to broaden the psychiatric aide role.

Manteno State Hospital: \$292,300 Federal Hospital Improvement Project Grant for three years to reduce overcrowding by accelerating movement of elderly patients back to their communities.

Dixon State School: 1) \$100,000 Federal Hospital Improvement Project Grant for three years to improve use of institutional and community resources. 2) \$60,000 Neurological and Sensory Disease Service Project Grant for five years for an audiological evaluation of institutionalized mentally retarded patients. 3) \$1,225 USPHS Grant for equipment to study the primary teeth of mentally retarded children. (Note: This grant has been awarded yearly for varying amounts since 1957.) 4) \$160,000 Neighborhood Youth Corps Grant from the Anti-Poverty Act to train unemployed youths between the ages of 16 and 22 to work in the various School Services. 5) As of December 1964, 100 people had enrolled in the Manpower Training Act Housekeeping Program. Fifty-nine have graduated. Of these, 50 have been employed. 6) There were 276 enrollments under the Manpower Training Act Psychiatric Aide Program

as of December 1964. One hundred and forty-five have graduated. Of these, 122 people have been employed.

Division of Planning

The Division of Planning and Evaluation is the Department's newest division. It was established in June and differs from many other state planning endeavors in these two respects: It is a permanent body concerned with program development and program evaluation in its fullest aspects both for the immediate future and for long term goals. The second difference is the division's professional climate centered around community psychiatry and, of greater importance, a strong commitment towards the future prevention of mental illness.

To reach these goals requires certain specialized skills in addition to a comprehensive knowledge of the field of mental health. The division's organization chart reflects this. Staff members are:

Leo Levy, Ph.D., S.M. Hyg., Director
 Ralph W. Collins, M.A., A.C.S.W.,
 Assistant Director Metropolitan Chicago
 Samuel Weingarten, Ph.D., A.C.S.W.,
 Assistant Director Downstate
 John B. Acheson, B.S., Chief,
 Program and Liaison
 Allen N. Herzog, Ph.D., Chief,
 Data Collection and Analysis

Mary E. Monahan, Communications Specialist

At the present time the division has some 22 studies and projects in progress. They range from Mental Health attitude surveys to the problem of the mentally ill aged population. The results will assist the division and its Mental Health Planning Board state-wide councils in drawing up Illinois' comprehensive mental health plan this year, and serve as a blueprint for planning and implementing new mental health program within the state.

Statistics

<i>State Hospitals</i>	1963	1964
Average Daily Resident		
Population	39,846	38,804
Admissions	16,932	17,841
Absolute Discharges	14,016	15,536
Percentage of Overcrowding	29.9	25.1
Total Full-Time Personnel	11,555	12,468
Patient-Employee Ratio	3.0	2.7
<i>Schools for the Retarded</i>	1963	1964
Average Daily Resident		
Population	9,988	9,894
Admissions	589	666
Absolute Discharges	184	244
Percentage of Overcrowding	42.1	36.3
Total Full-Time Personnel	2,658	2,881
Patient-Employee Ratio	3.9	3.5

Needs

Continued support of the executive and legislative branches of government for program and

budget. This support will enable the Department to staff its new facilities and increase staff at its present institutions. This will result in more intensive treatment programs and further decrease overcrowding by returning patients to their communities more rapidly.

Harold M. Visotsky,
Director, Department of Mental Health

APPENDIX #4

POLICY COMMITTEE S-5

The work on the Policy Manual has extended over approximately a two year period and has involved several phases of activity. The first ground work was to check the minutes of the House of Delegates and the Council (Board of Trustees) for the past 10 years. From this material, the Committee has developed the "Policy Manual" reproduced and to be found in the packet being prepared for the members of the 1965 House of Delegates.

The Committee, after serious consideration, voted to approach the problem with the idea in mind of developing policy on a "code" basis—then to assume that the committees would write their own "rules and regulations" under which they would operate and which would change from time to time. These changes could be made without difficulty, and without involving the basic principles on which the policies have been established.

For example: "mass surveys" could involve the Committee on Tuberculosis, the Committee on Cardiovascular Disease, the Committee on Diabetes, the Committee on Child Health, etc. By approving "mass surveys in principle" these committees could function in various ways without the alteration of any basic policy established by the Illinois State Medical Society.

By adopting this approach, the volume of material presented in the "manual" was cut by about two-thirds. The committee may have omitted some important policy by using this procedure. We hope all members of the House of Delegates will consider the manual carefully and make suggestions for the consideration of the committee.

The manual was submitted to the Board of Trustees at the March meeting and is being submitted at the 1965 meeting of the House, for action prior to publication.

The Committee would appreciate an expression of opinion from the House relative to establishing policy on non-medical subjects (i.e. electoral college reform—presidential succession, etc.) as a printed portion of the manual itself. If special action is taken in any area such as the two examples above, should it be for a specific instance and not incorporated in the policy of the Society as published.

The manual is always subject to change, deletion, addition, etc. and the committee will welcome co-operation, constructive criticism and assistance.

Newton DuPuy, *Chairman*

Arthur F. Goodyear

Frank J. Jirka, Jr.

REPORT OF EXECUTIVE ADMINISTRATOR S-6

In my report to the 1964 House of Delegates I listed 44 key activities which I supervise in managing the staff and committee functions of the ISMS. Each year that list of activities is lengthened because new projects are continually being added to staff and committee responsibilities as a result of increased interest on the part of individual members and actions by the House of Delegates. As this list has grown increasingly longer I have found it necessary to devote less time to doing things myself and much more time to *managing*. By managing, I mean planning, organizing, coordinating, motivating and controlling. In the final analysis these functions are what the Board of Trustees requires of me and why I am employed as the Executive Administrator.

Management experts frequently admonish men like myself to avoid the thought that "it's easier to do it myself than to have someone else do it." My chief responsibility is to plan the work of the staff, to organize the staff to get the job done, to coordinate the doing, to motivate the staff and committees to move ahead, and at the same time to control the quality of the results. Even though this be true, there remain certain activities in which I must be the "doer." Throughout the past year I have served as the unpaid Executive Director of the Illinois Association of the Professions. This has been done with the sanction and at the request of the Board of Trustees. I continue to serve certain committees which are of an important nature and which require my diligent attention such as the Executive and Finance Committees, the Advisory Committee to the Woman's Auxiliary, and the Liaison Committee to the Illinois Pharmaceutical Association.

There are certain other activities which require my "doing," such as visits to county medical societies, appearances before key meetings such as district meetings of the Woman's Auxiliary, and the ISMS, attendance at special conferences called by committees such as the Legislative Conference, the Public Affairs Conference, meetings with the Department of Registration and Education, appointments with the Governor, etc.

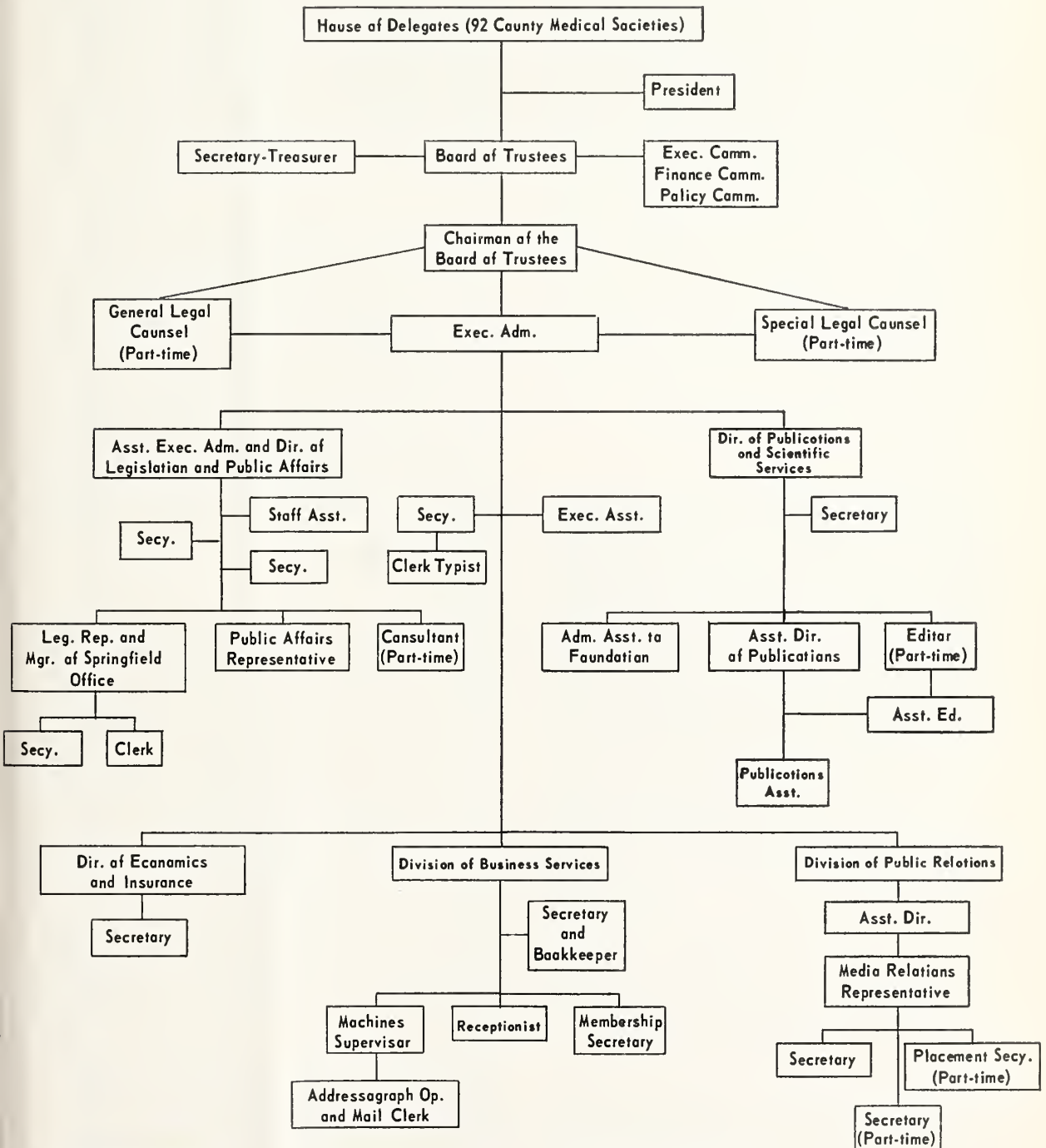
There are also key administrative meetings which require my personal presence and supervision for the preparation of appropriate minutes and communications with the staff. Typical of these is a weekly staff conference with all division directors, preparation of detailed agendas for the Finance Committee, Executive Committee, the Board of Trustees, meetings of the House of Delegates and special meetings such as the annual meeting with the Deans of the Medical Schools.

Planning

Other phases of my work require more actual

ISMS STAFF ORGANIZATIONAL CHART

(As of January 1, 1965)



29 Full-time Employees

1 Foundation Employee

6 Part-time Employees

time than the "doing functions," which I have briefly touched on above. *Planning*, for example, envisions the establishment of goals for the year, the explanation of policies to staff and committees, and the outlining of the course of action to accomplish the objectives. Scheduling work for the staff as a whole, or for each of the divisions, is part of the planning function which I must accomplish.

The preparation of the budget, and explanation of the budget, as well as the development of short term goals for each of the committee budgets must be prepared on the basis of plans submitted by committee chairmen. These budgets must be readily recognized by the Finance Committee and the Board of Trustees so that they can accept at least a short term responsibility for completion and then decide how much money is to be allocated.

Program planning with clearly defined goals enables the Board of Trustees to judge the over-all effectiveness of our day to day activities. It also enables the Board of Trustees to control activities of the staff, and the expenditure of money during the year. In 1962 a special report was presented to the Board of Trustees in which the staff outlined future administrative objectives. The objectives contained in that report are now virtually accomplished and completed. This is what I refer to as able planning on the part of the staff and is therefore one of my chief areas of concern.

Organizing

Another major portion of my time is spent in *organizing*. By organizing I mean the responsibility to tighten up the staff organization by establishing a clear-cut table of organization with crisp definitions of responsibility and authority. Position descriptions and written policies are all available, but these must be revised upon occasion. An example of organizing our staff activities is illustrated by the use of our staff implementation schedule which was developed over the period of the last year. By the use of this schedule every staff member was aware of important events of which he was a part, and what other staff members were involved in for several months in advance of completion.

Another illustration is the organizational phase necessary to carry out the Informational Program on Eldercare. Although staff was available and capable of performing the job, the Informational Program came at a time when all reports for the annual convention were to be completed, arrangements for the annual convention were being made in all its detail, and activities of committees were at an all time high. The organization of the Informational Program and how the assignments had to be integrated with other work of the staff consumed an appreciable portion of my personal time.

Coordinating

An increasing portion of my time is spent in *coordinating* staff, committee and Board of Trustees activities. The groundwork for coordination is laid

when the plan is complete. Complications however are bound to occur, and it is my responsibility to negotiate or discuss with staff members how they can perform their functions better. Under our committee type of organization, it is my responsibility to insure that the right hand knows what the left hand is doing. For example, the correlation of all reports to the Board of Trustees, the appearance of committee chairmen to present their reports, the preparation of minutes, and the summary which is sent to county medical societies is really a task of coordinating all materials for several weeks before and after a board meeting.

Another illustration during this past year was the planning and coordination of the special meeting of the House of Delegates, which included notification of all delegates, preparation of the agenda, material necessary to be presented, provision of adequate space, minutes and abstracts, all of which is part of my job in coordinating our various division functions. Another one of my principle assignments is to serve the individual officers and trustees as a coordinator of their district activities. The preparation for district meetings, adequate communications to keep them informed on what is happening, as well as providing them with up-to-date information so that they are in a position to make key decisions for county medical societies is also a part of my coordinating responsibilities. A similar coordinating responsibility is preparation for two AMA meetings each year, the development of materials for the delegates, preparation of agendas for their meetings, adequate hotel facilities, and local arrangements for the delegation and officers.

Motivation

Motivation in association management is a difficult task. However, it becomes my pleasure and duty to motivate the staff and through them to provide committee members with proper tools and the desire to complete their work to the satisfaction of the Board of Trustees. Most of the members of the medical profession are motivated by a desire to serve the association and look for few rewards except the satisfaction of rendering service to their profession. Some of their rewards come in terms of their presiding at meetings, social gatherings, as well as satisfying the public interest which is so important to organized medicine.

Staff members also need to have their share of rewards. Economic motivations are important, and therefore I have the responsibility to administer fair salary policies, to suggest fringe benefits, and to give them the opportunity for advancement. During the past year for example, many new tasks have been added to staff responsibilities, but there has been added only one new part-time secretarial employee assigned to our Public Relations Division. The major portion of this new employee's time is paid for by the Illinois Association of the Professions and by funds for administrative purposes

made available by the Illinois Medical Assistants Association. As I have done in previous reports, a copy of the staff chart as of Jan. 1, 1965, is attached as an appendix to this report for the information of the House of Delegates.

The motivation of our employees to take on new, different, and perhaps very challenging tasks remains my personal responsibility, and cannot be delegated. High on priority during this past year for example, was the motivation of staff to provide the necessary data for inclusion in the first Reference Issue of the Illinois Medical Journal. Although difficult to accomplish, this task was performed, and we now have the basis for an annual Reference Issue which will be improved each year. Many compliments have been received regarding that issue, and the Board of Trustees has authorized its continuance.

Controlling

My final responsibility is *controlling* the activities of the staff to the extent that they will remain within the allocated budgets, increase the amount and quality of work accomplished, and complete their objectives for the year. Under an increasing work load, quality control must be maintained, or slipshod work will result. Establishing high standards for staff performance and maintaining these same high standards is an important part of my duties. Measuring their performance in the light of their assignments and in the importance of their activities is a continuing responsibility. For example, a critique of each major function is usually held by me during staff conferences. An effort is made to inspect those areas which may be improved upon and to make certain that functions not performed well will be performed better in the future. The annual convention, for example, is an enterprise which must be carefully controlled. Staff is at its peak of work, arduous hours are spent in preparation, thousands of physicians are expecting an excellent meeting, exhibitors are requesting services, officers and trustees are meeting during the sessions, social functions are occurring daily, all of which makes it necessary to maintain tight control if the meeting is to be completely successful.

The executive association manager has been likened to a coxswain in a racing shell. He can't row it all by himself, and the oarsmen can't see the racecourse ahead. Therefore, the coxswain must plan the race, organize the oarsmen, coordinate their efforts, motivate them to row harder, and control their stroke by the cadence. In respect to my responsibilities to the Illinois State Medical Society for the administration of the staff, I believe this to be a true corollary.

Administrative Reports

During the past year I have presented *administrative reports* at each meeting of the Board of Trustees covering my detailed activities. Minutes of staff conferences are in record for review, and

because of the importance of some of the staff conferences, copies of the minutes have been sent to the officers and trustees.

It has been my responsibility to also prepare summaries of the actions of the Board of Trustees and disseminate them to delegates and officers of county medical societies. The record of these summaries is also available for review by the House of Delegates.

In the performance of my functions during this past year, I have received the complete cooperation of the officers and trustees. My special appreciation is extended to the officers, Dr. Adams, as Chairman of the Board of Trustees, Dr. Piszczek, as President, Dr. Montgomery, as President-Elect, Dr. Reisch, as Secretary-Treasurer, and Dr. Cannady as Speaker of the House of Delegates.

I believe the work of the staff particularly at this time of the year speaks for itself because the record is contained in the reports of the various committees. As indicated in my report for 1964, I sincerely believe that our staff is characterized by selflessness rather than selfishness, by activity rather than apathy, and by a concern for the organization rather than for their individual needs. I am sure that our staff as well as I look forward to another year of significant administrative progress.

Robert L. Richards

COMMITTEE TO STUDY COMMITTEES S-7

The Committee to Study Committees has observed the functions of the committees during the year 1964-65. Very few changes in the functions of the committees have occurred, and there are only a few minor changes in definitions which we expect to discuss with the Executive Administrator. During the past year there were no committee chairmen who had any difficulty in properly interpreting the responsibilities placed upon his committee.

In January, 1965, the committee, through correspondence, agreed that there would be no need for having a detailed review of the committee structure.

Therefore, we recommend to the House of Delegates that no new committees be added, or major changes be made for the year 1965-66.

Caesar Portes, *Chairman*

Bernard Klein	William H. Schowengerdt
Ted LeBoy	W. C. Scrivner
Jacob E. Reisch	C. K. Wells
Paul P. Youngberg	

DELEGATION TO THE AMA HOUSE S-8

Physicians holding key positions at the county, state or national level are bombarded with information dealing with medical politics, the science of medicine, the economic and legislative situations at the state and national scene. The reports of the

ISMS delegation to the AMA House, as a result, have become more curtailed to avoid unnecessary duplication.

Three meetings of the AMA House have been held since the report was made to the 1964 House of Delegates of the Illinois State Medical Society last May. This report is compiled in a manner to reflect the activities of our physicians at these three sessions, and present for your consideration and information, the conduct of Illinois affairs by your elected representatives.

To exert the maximum influence and to have the necessary educational program for the alternate delegates, the ISMS Board of Trustees has authorized the payment of expenses (a per diem and transportation) and (1) all delegates; (2) alternate delegates, and (3) the president, president elect and chairman of the Board. Under some circumstances, this might represent 25 Illinois physicians in attendance; however, in many cases the president, president elect and chairman of our Board hold positions on the elected delegation.

Reference Committees and Illinois Activities

Percy E. Hopkins holds the position of Chairman of the Board of Trustees of the American Medical Association, and Walter C. Bornemeier serves its House of Delegates as Vice Speaker.

At San Francisco, June, 1964:

Harlan English—Reference Committee on Executive Sessions

Arthur F. Goodyear—Reference Committee on Reports of the Board of Trustees

Maurice M. Hoeltgen—Reference Committee on Insurance and Medical Service

Burtis E. Montgomery—Reference Committee on Miscellaneous Business

At Miami Beach, November, 1964:

H. Kenneth Scatcliff, Chairman, Reference Committee on Miscellaneous Business

Leo P. A. Sweeney, Reference Committee on Legislation & Public Relations

Carl F. Steinhoff, Reference Committee on Rules and Order of Business

At Special Called Meeting—Chicago, February, 1965:

Harlan English, Chairman, Reference Committee on Rules and Order of Business

Illinois Resolutions

At San Francisco:

At the San Francisco meeting, the Illinois Delegation introduced Resolution #46 dealing with "Cigarette Smoking as a Health Hazard." Similar resolutions were received from several other states and the Reference Committee presented a substitute statement embodying the general consensus from the total grouping, which was approved by House action.

Resolution #54 "Revision of Simplified Health Insurance Claim Forms" received consideration by

the Reference Committee, which recommended that the best way to implement the requests was to bring the matter to the attention of the Committee on Insurance and Prepayment Plans, and continue to work with this group to effect the proposed changes.

Resolution #64 paid tribute to Dr. Josiah J. Moore, treasurer of the AMA for over 14 years. Dr. Moore died shortly before the San Francisco meeting.

A copy of the ISMS resolution supporting the AMA position on blood bank activity "in the restraint of trade" was prepared and sent to the AMA. It was referred to the Council on Legislative Activities as a "matter of information and in support of existing policy."

At Miami Beach:

Two resolutions were introduced by Illinois.

Resolution #2, "Orientation of Official Representatives of Medicine Travelling Outside U.S.A." was not adopted since the Reference Committee felt that the AMA presently checks with the state and county medical societies before designating a physician as a representative and adoption of this resolution as presented would impose additional burdens upon the AMA funds and staff, and on the physicians themselves. The Reference Committee felt that the present program would accomplish the purposes embodied in the resolution if the physicians would avail themselves of the services and information already available.

Resolution #17 relative to the extension of the existing Kerr-Mills programs by the states, and the improvement of existing health care plans was referred to the Reference Committee on Legislation and Public Relations. It was considered with other similar resolutions and also with Supplementary Report K of the Board of Trustees. The resolutions were not adopted, but the House approved the report of the Board and expressed its unequivocal approval and confidence in the Board to vigorously and effectively implement its health care program.

Expenses of the Delegation

The members of the delegation are well aware of the fact that for the past two years it has been necessary for the Illinois State Medical Society to operate under a deficit budget. As many economy measures as possible have been instigated. However, the delegation must continue to represent the membership effectively and to exert as much influence at the national level as possible. It is the unanimous consensus that minimum expense now provides the membership of the ISMS with maximum representation.

The expenses of the delegation are now paid on a "per diem and travel" basis. The delegation holds its traditional Monday luncheon for delegates and alternates at the June meeting and provides Illinois hospitality at a headquarters suite at the clinical meeting.

The individual assignments for attendance at group meetings, reference committee sessions, other scheduled sessions, etc., have been combined and considered carefully by the chairman of the delegation to avoid duplication of attendance, effort and expense.

We hope to present the names of several Illinois physicians to the AMA House of Delegates in the future as candidates for elective positions. Dr. Warren H. Cole, Professor and Head of the Department of Surgery at the University of Illinois College of Medicine will be proposed to the AMA Board of Trustees for consideration as a candidate for the Distinguished Service Award. In preparing the necessary brochure the delegation is being assisted by the excellent and timely cooperation of the Dean of the University of Illinois College of Medicine, Dr. Granville A. Bennett.

While the scientific side of the AMA meetings is being considered, the House of Delegates should recognize the excellent representation of Illinois physicians in the scientific sessions of the AMA.

FILM:

"Modern Management of Multiple Births" produced under a grant to the ISMS was scheduled at the San Francisco meeting.

Exhibit Winners:

At San Francisco: Three "certificates of merit" were given to Illinois physicians and three exhibits received "honorable mention." Several Illinois physicians participated in the fracture exhibit and one Illinois physician received an award in the American Physicians Art Association's 27th annual exhibit.

Scientific Speakers at Miami:

At the Miami meeting Illinois physicians ap-

peared on the breakfast round tables, before the section meetings, and many participated in the preparation and presentation of the scientific exhibits.

AMA-ERF:

At the opening meeting of the House of Delegates in Miami Beach on Monday, Nov. 30, Dr. Edward A. Piszczek, as president of the Illinois State Medical Society, had the privilege of presenting a check for \$187,500 to the AMA-ERF as the 1964 contribution of Illinois physicians through the \$20 allocation from dues. This brings the total Illinois contribution to more than \$2,000,000.

Through long range planning on the part of the Illinois delegation, it is hoped that your representatives will continue to exert influence, reflect the views of our own House of Delegates and represent Illinois medicine in an effective and progressive program geared to benefit not only residents of this state, but of this country as well.

The delegation extended official commendation and sincere appreciation to Dr. Sweeney for his services during the past two years as the chairman of the delegation. The delegation also acknowledges the assistance and the services of the headquarters staff which has worked throughout the year to provide the ISMS delegates with the information and the background needed to function efficiently during the annual and clinical sessions.

Edward W. Cannady, *Chairman*

Maurice M. Hoeltgen, *Secretary*

Walter C. Bornemeier

Harlan English

William K. Ford

Frank H. Fowler

Arthur F. Goodyear

H. Close Hesseltine

Burtis E. Montgomery

H. Kenneth Scatliff

Leo P. A. Sweeney



COMMITTEES ASSIGNED TO DIVISION OF ADMINISTRATIVE ACTIVITIES

COMMITTEE ON THE ILLINOIS ASSOCIATION OF THE PROFESSIONS AC-1

True interest is manifest in several areas by participation in meetings, liaison, study, and membership growth. Illinois Association of the seven Professions chartered February, 1964, grew in one year to 460 individual membership of whom 145 are in medicine. Such is unique progress. Due credit has been repeatedly directed to Illinois medicine's officers, members, and staff as ground work group. In the foreseeable future it is only fair to plan that Mr. Richards, whose able services have

been generously loaned the new group, should receive compensation therefor.

A combination of its annual meeting and its inauguration of officers meeting is being studied. Several regional meetings of professions have developed across the state. Some repeated, as did Lake County, for a third year rotating sponsors. Mutual benefit should accrue to state and local groups as they grow to share in experiences and membership.

Monthly liaison with the Illinois Interprofessional Council led by Dr. Brislen presented before that group the profile of Illinois medicine. He was

aided by staff in that interesting task.

Members of our committee have served in other liaisons. At times, matters are referred to Trustees or committees in districts concerned. President Piszczek and Dr. Lull counsel has been generous and appreciated.

At the national medical legal symposium the American Bar Association and the American Medical Association in March, those two co-sponsored it for the first time in their 10-year relationship. Previous regional and one national meeting of the two have been AMA sponsored. We in Illinois will gain knowledge from such studies. In turn some are interested in our more inclusive Illinois Association of Professions group already functioning.

Your chairman invited as the first president of IAP will speak on a national panel in Grand Rapids at Michigan's annual assembly of the professions.

At the World Medical meeting in Helsinki, 1964, a committee chairman, who had reported upon international bar and medical liaison, requested data be sent regarding IAP.

In 1965, a delegation of ISMS in cooperation with People to People and sanctioned by AMA will visit South American countries. Various professionals at home and abroad will join our state-wide group in an unusual and challenging experience.

Bimonthly reports in more detail have been given to the Board of Trustees. A report of our committee meeting to be held before the May House of Delegates session will present a supplement of intervening events.

Your chairman extends the committees' gratitude to officers, members, and staff in their support of its efforts and my personal thanks to the members of my committee.

George B. Callahan, *Chairman*

Charles Allison James D. Majarakis

Andrew J. Brislen Vincent C. Sarley

Michael R. Saxon

COMMITTEE ON LIAISON WITH THE ILLINOIS PHARMACEUTICAL ASSOCIATION AC-2

Study continues on the Code of Cooperation between our two associations. A summary of such is to be carefully reviewed by our Board of Trustees, delegates, and members with a few overall advice before the committee seeks action upon any given set thereof.

A few cases of mutual concern in local relations across the state have been referred to appropriate officers and committees concerned with such matters.

Meetings of the two committees in liaison are on call.

George B. Callahan, *Chairman*

George F. Lull Edward A. Piszczek

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY AC-3

The Advisory Committee to the Woman's Auxiliary has met one time at which time many important issues were discussed. One of the greatest problems confronting our Auxiliary today is that of membership. It seems that many, many women are not particularly interested in the Auxiliary; neither are their husbands. Our honored president, Mrs. Willard Scrivener, has done a tremendous job in spreading the gospel throughout the state. She is well received wherever she goes and one of her prime objectives is to attempt to get medical dues for the Auxiliary paid simultaneously with the doctors' dues for the Illinois State Medical Society. This I believe would be a great step forward and would produce many more members for the Auxiliary.

In the local areas, the Woman's Auxiliary is doing a tremendous job insofar as writing congressmen spreading the gospel about Medicare and Eldercare. They're writing letters, having teas, and doing many of the things which we as doctors probably would not have time to do and could not do as well were we to attempt to do so.

There is scheduled another meeting of the advisory committee in March at the time of the Illinois State Medical Society Board meeting in Chicago. We hope at that time to consummate some of the discussions that we have had before and to try to have some concrete recommendations to the Board with reference to membership in the Auxiliary.

It has been a distinct pleasure serving in this capacity particularly with such wonderful people as our honored president and her board. My congratulations to them for a job well done.

Burtis E. Montgomery, *Chairman*

William E. Adams Edward A. Piszczek

COMMITTEE ON CONSTITUTION AND BYLAWS AC-4

The Committee on Constitution and Bylaws has received proposals for changes in the Bylaws in the following sections:

(1) Membership

The Membership Committee of the Illinois State Medical Society, acting under "instructions from the House (of Delegates) to submit proposed revisions in the membership sections of the Illinois State Medical Society Bylaws" submitted "proposed Bylaws sections on membership matters" for consideration.

The material presented first to the Board of Trustees Jan. 17, 1965, and included verbatim in the report of the Membership Committee appearing in this issue of the Illinois Medical Journal, has

been received too late for consideration and comment in this report.

(2) Appointment of Reference Committees

The suggestion that the Speaker and Vice Speaker be given greater authority in the appointment of reference committee members has again been made.

(3) Residence as a requirement for membership

Physicians who practice exclusively in Illinois,

but who reside in another state are not eligible for ISMS membership.

Recommendations on these proposals will be the subject of a supplementary report to be submitted by the Committee before the annual meeting.

Andrew J. Brislen, *Chairman*

David S. Fox

M. Mijanovich

Wayne N. Leimbach

Charles J. Weigel

Ex-officio: Edward W. Cannady

COMMITTEE ASSIGNED TO DIVISION OF BUSINESS SERVICES

MEMBERSHIP BC-1

Committee action during the past year focused on the 1964 House of Delegates request for a revision and consolidation of ISMS Bylaws material into one section organized along the lines of the AMA membership Bylaws sections. All points from members and others pertaining to membership, were extensively explored for the proposed changes in the Bylaws.

At the January, 1965 meeting of the Board of Trustees, the committee's recommended revision of the Bylaws was presented for review and approval. The committee's recommended changes were approved and referred to the Constitution and Bylaws Committee for introduction at the 1965 meeting of the House of Delegates.

The Membership Committee's proposals, which consolidate all material on membership into five Bylaws chapters are reproduced below in outline form.

OUTLINE OF BYLAWS

Chapter I—QUALIFICATIONS AND ELIGIBILITY FOR MEMBERSHIP

Section 1. Members shall be ACTIVE or SPECIAL

a). ACTIVE members shall be Regular, Emeritus, Retired, Provisional, Intern and Residency members

b). SPECIAL members shall consist of Associate, Affiliate, and Honorary members

Section 2. Qualifications for ACTIVE membership

a). Regular membership minimum requirements

b). Also eligible, with exceptions to a). above

c). Emeritus membership qualifications

d). Retired membership qualifications

e). Provisional membership

f). Intern membership

g). Residency membership

Section 3. Qualifications for SPECIAL membership

a). Associate membership eligibility

b). Affiliate membership eligibility

c). Honorary membership eligibility

Chapter II—TENURE

Section 1. Payment of dues prima facie evidence of membership

Section 2. Retention of membership

Section 3. Withdrawal of privileges

Section 4. Change of residence within the state

Section 5. Termination of membership

Chapter III—DUES, FUNDS, AND ASSESSMENTS

Section 1. Dues

a). How prescribed

b). Method of payment

c). Dues and journals

d). Special dues rates

(1). Teaching, research and administrative members employed in Illinois medical schools

(2). Full-time teaching or research in a not-for-profit institution

(3). First year of practice

(4). New members approved after June 30

e). Exemptions from dues

(1). Financial hardship

(2). A member temporarily in the Armed Forces

(3). Board of Trustees authorization

f). Delinquency after April first

Section 2. Funds and assessments

a). Funds may be raised by

(1). Annual dues approved by House of Delegates

(2). From publications of the Society

(3). In any other manner approved by the Board of Trustees

b). Funds may be appropriated by the Board of Trustees

(1). To defray the expenses of the Society

(2). To carry on its publications

(3). To encourage scientific investigations

(4). For any other purpose approved by the Board of Trustees

Chapter IV—DISCIPLINE

Section 1. Ethical Relations Committee

Section 2. Cause for censure, suspension or expulsion by county society

Section 3. Procedure

Section 4. Referral of complaints to ISMS to a district Ethical Relations Committee

Section 5. Applicable principles of justice to guide disciplinary action

Section 6. Maintenance of stenographic record

- Section 7. Committee sitting as a trial body
- Section 8. Review of appeals by ISMS Board of Trustees
- Section 9. Report of decision to entire Board of Trustees
- Section 10. Notification to accused of right of appeal
- Section 11. Notification of defendant and county society of action of the Board
- Section 12. Remanding of case to county society for reconsideration

Chapter V—COUNTY SOCIETIES

- Section 1. County society affiliation
 - a). Charter for component county societies
 - b). Issuance of charters by the Board
 - c). Only one component society chartered in any county
- Section 2. Member relations
 - a). Eligibility of physicians for membership in component societies
 - b). Right of member to appeal disciplinary action to the Board of Trustees
 - c). Membership for physicians living on or near a county line
- Section 3. Records and procedures
 - a). Requirement that county society secretary maintain roster of membership
 - b). County roster forwarded to State Society before February first

- c). Requirement for payment of county's annual assessment by April fifteenth

Briefly, additions proposed to content of the membership sections of the Bylaws are:

1. Enlarge category of Honorary members to provide for three Special categories—Associate, Affiliate, and Honorary.
2. Introduction of new chapter dealing solely with Dues, Funds, and Assessments. Develop according to terminology used in similar sections by AMA. Include all material in present Bylaws dealing with members' dues requirements and exemptions.
3. Those physicians in government service that are eligible for membership shall be expanded to include any U.S. Government service in which they are *serving full-time as a physician*.
4. Emeritus membership qualifications to be *January 1* following the member's 70th birthday.

Our committee is available to any county society having questions on matters relating to membership, including the encouragement of enrollment of new members. Organized medicine should represent the overwhelming majority of all physicians (via their membership in our societies).

H. Close Hesseltine, *Chairman*

W. C. Bornemeier Harold E. Himwich
Casper Epsteen Joseph O'Malley
H. D. Scott, Jr.

COMMITTEES ASSIGNED TO DIVISION OF PUBLIC RELATIONS

DISASTER MEDICAL CARE COMMITTEE PC-1

The major accomplishment of the Disaster Medical Care Committee during 1964-65 was the establishment of a unique Civil Defense Emergency Hospital training program, Nov. 21, in Elmhurst.

The program—designed to train hospital and civil defense personnel in setting up and utilizing the CDEH unit—was conceived and implemented by the Committee, but co-sponsored by ISMS, the Illinois Department of Public Health and Memorial Hospital of DuPage County in cooperation with the Illinois Department of Civil Defense and the regional office of the U.S. Public Health Service.

More than 200 hospital and civil defense personnel attended the program, believed to be the first of its kind in the country. During the eight-hour session, trainees were taught to uncrate, establish and operate the various components of the 200-bed CDEH unit. It is hoped that this pilot program will stimulate similar local programs for hospital and civil defense personnel throughout the state.

Shelters Under Highways

Another major project was the development of a proposal calling for the construction of fallout

shelters beneath elevated highways to protect Americans away from home in time of nuclear disaster. We believe that the massive earth and concrete supporting elevated highways—and encasing these shelters—would provide ideal shielding against ionizing radiation following a nuclear blast.

Our proposal—published in the December, 1964, issue of the Illinois Medical Journal—received statewide publicity and support from the Architects Association of Illinois and the Illinois Society of Professional Engineers who have appointed a joint committee to work with us.

Meanwhile, the Committee is conferring with DuPage County officials on the possibility of building a prototype shelter beneath a proposed highway in that county. A meeting with Gov. Otto Kerner is also planned to implement the program on a statewide basis.

The Committee also persuaded station WTTW, Channel 11, to re-telecast our 15-part series on Medical Self Help Training. The 30-minute program, which is seen at 9:30 p.m. Tuesdays was launched Feb. 22 and will continue through May 31.

Radio and Television Activities

The remainder of the Committee's work was in the area of broadcasting and public appearances.

Over the past 12 months, we made seven radio and television appearances and fulfilled 24 different speaking engagements, discussing Medical Self Help Training, mass casualty care, fallout shelters, etc., to schools, nurses, hospitals, public health groups and women clubs and church organizations.

Following are the proposed activities for 1965-66:

(1) Continue our Civil Defense Emergency Hospital Training Program; (2) Publish and distribute a revised edition of our Disaster Manual for hospitals; (3) Continue the Medical Self-Help Training Program; (4) Continue our fight against the use of large expanses of ordinary glass in the construction of public buildings; (5) Continue training medical and para-medical groups in Disaster Medical Care; (6) Encourage the construction of a vast network of fallout shelters beneath elevated highways.

The committee wishes to acknowledge the splendid cooperation it received from the ISMS Public Relations Division and the various governmental agencies—particularly the Regional Office of the U.S. Public Health Service—the Illinois Civil Defense Agency and the Illinois Department of Public Health.

It is the opinion of the chairman of this committee that these factors would certainly tend to confirm that organized medicine can work efficiently and profitably with various governmental agencies. The chairman is equally convinced, however, that organized medicine cannot work for governmental agencies.

Max Klinghoffer, *Chairman*

Jack Baldwin

Charles W. Young

Harold C. Lueth

Carl F. Steinhoff

Auxiliary: Mrs. John M. Tindal

The Committee also conducted its annual survey of county societies regarding the handling and disposition of ethical relations cases on the local level. The survey showed that only three other disputes involving medical ethics were heard during the past year.

In one instance, a physician was censured for advertising. A second case, involving excessive fees, was resolved on the local level to the satisfaction of the physician, patient and county society. Another case, involving overtreatment and excessive fees, is still pending.

This does not reflect the entire story, however, since the Chicago Medical Society actually has three other committees screening complaints which otherwise might come before the Ethical Relations Committee. Only those cases warranting the attention of the Ethical Relations Committee are referred to it, while others are disposed of by other committees.

The survey also revealed that—of the 51 county societies responding—only 17 have Ethical Relations Committees. Ten others refer such cases to their Grievance Committees, while seven refer them to their Board of Censors. The remainder do not have committees established for that purpose. As a result of this inconsistency, the committee sent letters to all county societies requesting uniformity in the naming of committees empowered to handle medical ethics problems. It was suggested they adopt the name "Ethical Relations Committee" for groups working in that area.

Charles Allison, *Chairman*

V. B. Adams

Carl Steinhoff

Warren W. Young

Jerome Joseph Burke

COMMITTEE ON ETHICAL RELATIONS PC-2

The primary function of the Ethical Relations Committee is to serve as an appellate body to review cases of alleged misconduct referred to it by component societies or appealed by individual physicians. Last year, the Committee sat in judgment on appeals from two physicians expelled from their county medical society for unethical conduct.

One case involved overtreatment and excessive fees; a second case involved the conviction of a crime and misappropriation of hospital funds.

In considering these appeals, the Committee reviewed transcripts of the county medical society hearing and listened to testimony from the physicians and their witnesses. After considerable deliberation, the Committee recommended that the ISMS Board of Trustees uphold the county medical society decision. The Board concurred, whereby both physicians appealed to the American Medical Association's Judicial Council. While AMA hearings were conducted in February, no decision had been rendered as of this writing.

FIFTY YEAR CLUB PC-3

Some 51 physicians were initiated into the ISMS Fifty Year Club in 1964, bringing the organization's membership to 535.

Among the initiates were former ISMS President Dr. James Hutton and 33 members of the Chicago Medical Society who received their certificates and pins at the club's 1964 luncheon meeting. Downstate physicians received their pins at various meetings of their county societies throughout the year.

The club's annual luncheon—held in conjunction with the society's 1964 convention in May—was the highlight of the year, as evidenced by an all-time high attendance of 170 physicians. Feature stories and photographs of the event were published in newspapers throughout the state. Dr. George Lull, a past president of the society and a member of the Fifty Year Club, presided in the absence of Dr. Morris Fishbein who was out of the country. Alex Dreier, popular news commentator, was the guest speaker.

The 1965 luncheon is scheduled for Tuesday, May 18, in the Louis XVI Room of the Sherman House.

Morris Fishbein, *Chairman*
George F. Lull G. C. Otrich
Walter Theobald

GRIEVANCE COMMITTEE PC-4

With the exception of those cases still pending, all of the 458 reported complaints against ISMS physicians the past year were settled on the local level by county medical society committees. Of the 52 county societies submitting annual reports, only 10 reported official complaints.

Following is a tabulation of the reports, with the Chicago Medical Society considered apart from the smaller, downstate societies.

Chicago Medical Society	
Number of complaints	409
Cases pending	61
Breakdown of complaints	
(a) Excessive fees	156
(b) Service	76
(c) Others	177
Manner of Settlement	
(a) Through satisfactory explanation	289
(b) Through reduction in fees	47
(c) Through other means	12
(d) Cases pending	61
Physicians upheld	109
Physicians censured or referred to county	
Ethical Relations Committee	2

Of the 51 downstate county societies reporting, Kane County reported 15 complaints, DuPage County reported nine, and Macon and Vermilion Counties reported eight each. No other county reported more than two complaints.

Downstate County Societies	
Number of Counties reporting	51
Number of complaints registered	49
Breakdown of complaints	
(a) Excessive fees	23
(b) Service	16
(c) Others	10
Manner of settlement	
(a) Through satisfactory explanation	25
(b) Through other means	3
(c) Through reduction in fees	12
(d) Pending	4
Physicians upheld	7
Physicians referred to	
Ethical Relations Committee	2

An analysis of the survey reveals that 179 of the complaints regard physicians' fees. While this total is lower than previous years—184 were reported last year and 200 the year before—they still represent 42 per cent of all complaints. This underscores the continuing need to educate both the public and profession on the advisability of

discussing fees prior to the rendering of service. Proof of this is found in the fact that three times as many complaints were settled through a satisfactory explanation of fees, rather than in a reduction thereof.

Arnell M. Vaughn, *Chairman*
Allison L. Burdick Frank H. Fowler
J. E. Wheeler Victor V. Rockey
A. K. Baldwin

ADVISORY COMMITTEE TO THE ILLINOIS MEDICAL ASSISTANTS ASSOCIATION PC-5

The principal accomplishment of the Advisory Committee to the IMAA during the past year has been the establishment and implementation of a formal program of assistance to the IMAA.

The program—requested by IMAA and approved by the ISMS Board of Trustees—was created at a joint meeting between representatives of the IMAA and ISMS Advisory Committee last fall. Its purpose is to provide the 380-member IMAA with all the financial, clerical and public relations assistance possible to help it realize its full potential as a service organization.

Details of our new program of assistance are as follows:

The Society will make available to IMAA part-time secretarial assistance and will counsel and assist in the implementation of all IMAA activities whenever feasible. While IMAA will reimburse the Society for such out-of-pocket expenditures as secretarial services, paper, printing, and plates used in IMAA projects, the services provided by the society's staff will be made available without charge.

Our Public Relations Director, who serves the Advisory Committee to the IMAA, will also serve as the staff coordinator on all IMAA projects channeled through the Society. We also pledge to assist IMAA in the following areas:

(1) Publicizing its activities; (2) Obtaining speakers for programs; (3) Assisting with arrangements for its annual convention; (4) Assisting with the preparation of the IMAA page in the Illinois Medical Journal; (5) Providing reproduction, clerical and mailing services; and (6) Providing reports, pamphlets and information on public affairs, economics and legislation.

As soon as it is feasible, the IMAA shall establish its official headquarters in the central offices of the Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

While our program of assistance has been in effect only six months, we are extremely pleased with its success. Following is a summary of our work with IMAA since its inception.

The state medical society's office is now recognized as the official headquarters of the IMAA, with many of its records and correspondence now on file there.

In February, our staff assisted IMAA President Mrs. Corinne Berg with the editing, publication and distribution of the organization's first monthly newsletter, "Executive Memo." Similar issues were published during March and April.

We are currently working with IMAA officers on the compilation and publication of the organization's history, and a special state-wide promotion designed to increase IMAA membership to 500. In addition, the ISMS staff has been invited to handle all advance and post publicity on the IMAA's annual meeting, Apr. 24-25 in Peoria.

It is the opinion of the chairman of this advisory committee that our new program of assistance has done more to enhance the relationship between the two organizations than any other project in the past.

Maynard Shapiro, *Chairman*

Donald E. Dick	H. H. Pilliger, Jr.
Clarence G. Glenn	William Scanlon
Thomas R. Harwood	Fred L. Stuttle
William G. McCarthy	Harold Swanberg
Ex-Officio: Carl E. Clark, Caesar Portes,	
Philip G. Thomsen	

PUBLIC RELATIONS COMMITTEE

PC-6

During the past year, the Public Relations Committee concentrated its efforts in four major areas: the establishment and promotion of a corporate symbol for the society; expansion of its radio and television services; utilization of outdoor advertising and an informational campaign on the Kerr-Mills and proposed Eldercare programs.

Creation of Dr. SIMS

Its most significant contribution was the creations of Dr. SIMS, the first corporate symbol ever devised and used by a medical organization. The adoption of Dr. SIMS—a stylized cartoon character whose very name represents a play on the society's initials—is designed to accomplish three objectives:

- (1) Strengthen our corporate identity.
- (2) Provide our public service promotions with the consistency they need.
- (3) Lend a personal touch to our newspaper column and radio and television public service programming.

It will also set apart ISMS public service programming from the thousands of other professional and health service organizations competing in the same PR markets (radio-TV spots, newspaper columns, pamphlets, etc.)

The idea of a corporate symbol for a medical organization is so unique that newspapers throughout the state carried feature stories on Dr. SIMS. PR Doctor—an official publication of the American Medical Association—gave the Dr. SIMS feature a three-page spread in its August, 1964 issue.

Dr. SIMS on Radio, TV

The first promotion undertaken with our new corporate symbol was the "Dr. SIMS Daily Health

Tips," a unique public service radio feature incorporating 30 half-minute health tips on a single acetate record. In subscribing to the service, stations receive a new record every month, thus assuring them of a different health message every day of the year.

The promotion proved so successful that 59 Illinois stations have subscribed to it and have been airing Dr. SIMS spots as often as six times a day since last June. Over the past 10 months, therefore, our messages have been aired some 54,000 times.

While production and distribution costs of this service totaled \$2,500 during that time, surveys show we have received about \$500,000 worth of public service air time for our money. This means ISMS is getting a \$200 return for every dollar invested in this project.

Station managers are almost unanimous in calling the Dr. SIMS Daily Health Tips one of the best public service features on radio. While our staff is responsible for their research and production, they are recorded by Dr. Max Klinghoffer, chairman of our Disaster Medical Care Committee. We extend our sincere appreciation to Dr. Klinghoffer for the time and effort he has devoted to this project.

Dr. SIMS made his television debut in September with a one-minute public service spot on the subject of measles. While all 20 of the Illinois stations aired the message during the fall months, some TV stations continued to telecast it as late as March.

Dr. SIMS Newspaper Series

In keeping with our campaign, Dr. Charles J. Weigel's Subcommittee on Media Relations incorporated the name and face of Dr. SIMS in the masthead of our popular "Safeguard Your Health" column. It is believed that the addition of Dr. SIMS' "personal touch" has increased the readership of the articles and—at the same time—strengthened our corporate identity.

Dr. SIMS at State Fair

The third phase of our promotion was the introduction of Dr. SIMS at the 1964 State Fair in Springfield last August. A three-foot high paper mache head of the stylized cartoon character was worn by members of our public relations staff to attract visitors to our exhibit. The result? Record-breaking crowds came in droves to meet Dr. SIMS and view our display. Parents and children alike shook hands with the ISMS symbolic emissary in what amounted to the most successful State Fair promotion in ISMS history.

He proved an ideal goodwill ambassador as he distributed to youngsters some 5,000 balloons bearing the face of Dr. SIMS and the inscription "Measles Cripples and Kills, Immunize Today." As balloons were being inflated in the exhibit area, waiting parents received more than two tons of health educational pamphlets from volunteers of Sangamon County Women's Auxiliary.

Dr. SIMS proved so popular that even Gov. Otto Kerner and his Republican opponent, Charles Percy, visited and posed for pictures with him.

Dr. SIMS in School

Riding the popularity wave of Dr. SIMS, the society chalked up another "first" in public service programming in January, 1965, when it introduced a "Dr. SIMS Talks To Teens" health column to high school newspapers. Schools responding to the promotion were sent one and two-column newspaper mats bearing the Dr. SIMS image and a semester's supply of health columns.

The monthly feature—believed to be the first health column ever offered to schools—was an immediate success as more than 375 public and parochial schools added the feature to its publications. The American Medical Association was so impressed with the Dr. SIMS approach to teenage health education that it is planning to follow in our footsteps with a similar column on a national distribution basis next fall.

Community Health Week

Another successful project was the 1964 Community Health Week promotion, Oct. 18-24, under the direction of Chairman Dr. Matthew B. Eisele. Instituted by this committee in 1962 as a state-wide observance of the excellent medical facilities available in Illinois, Community Health Week was adopted by the American Medical Association in 1963 as an annual, national observance.

As its "Founding Father," however, ISMS was expected to set a national example for its observance. Thus, we launched a full-scale CHW promotional campaign on physical fitness featuring former baseball great Stan Musial. Musial—national chairman of the President's Physical Fitness Council—served as honorary chairman of our program, the biggest in the three-year history of CHW. Following is an outline of the promotion.

Plastic Record—ISMS launched the 1965 CHW program with another "first" when it became the first medical society to publish a five-minute plastic record featuring a CHW message from Musial—in the text of its journal. The record was bound in the September Illinois Medical Journal as a special feature of the PULSE.

Pamphlet Racks—We printed and distributed some 2,000 CHW pamphlet racks and 500,000 brochures on physical fitness. The racks—featuring Musial and Dr. SIMS—proved so popular that we received twice as many requests as expected. Half of the 500,000 pamphlets were printed and donated to ISMS by the A. H. Wesso Foundation, Oak Park, with the remainder supplied by the President's Physical Fitness Council.

Radio Spots—We produced and distributed an acetate record with five public service radio spots on CHW—featuring Stan Musial—to more than 120 Illinois radio stations.

Medical Interview—A five-minute Medical Inter-

view tape on physical fitness—again featuring Stan Musial—was recorded and broadcast on 57 Illinois radio stations.

Press Releases—Press releases announcing the start of CHW, its aims and purposes, and suggested editorials were distributed to all of the state's 676 newspapers.

Medical Journalism Awards

To stimulate more and better radio-TV-press coverage of medical events—and acknowledge outstanding achievements in the field of medical journalism—the committee instituted the First Annual Medical Journalism Awards competition.

Invitations to participate were sent to every newspaper, radio and television station in the state, together with full instruction and rules for entrants. On Dec. 23—the deadline for entries—the ISMS office was deluged with entries, especially in the newspaper categories.

Rather than judge the entries ourselves—and possibly incur the criticism of losing entries—we invited Bill Irvin, TV columnist for Chicago's American, and James E. Green, midwest regional manager of TV Guide to judge the television entries with Dr. Bertram B. Moss of our Radio TV Subcommittee. Judges for the radio and newspaper entries were provided by the Publicity Club of Chicago, who were assisted by Dr. Weigel and Dr. Leo P. A. Sweeney.

A total of eight newspapers, four radio stations and a television station were singled out for special honors. The awards were presented at the First Medical Journalism Awards Dinner held Feb. 17, 1965, at Sarah Siddons' Walk in the Ambassador East, Chicago. Present were 75 members of the radio, TV and press, ISMS officers and Board of Trustees, the Public Relations Committee and staff.

Handsome, walnut plaques were awarded to the following winners: Chicago Tribune, Chicago Daily News, Chicago's American, Illinois State Register, Rockford Register-Republic, McLeansboro Times-Leader, Highland Park News, the Chicago Bulletin, and Stations WGN-TV, WIND, WJJD, and WAAF.

Judging from the enthusiasm of the media representatives—and the excellent radio-TV-press coverage received—the committee heartily endorses continuation of these awards.

News Broadcast Record

For the third consecutive year, our radio-TV speakers bureau set a broadcast record as ISMS compiled over 431 hours of public service broadcasting time in 1964—or 18 full days of air time. This is more than four times the record of the previous year. And 1965 looks even better, as we add more and more programs to our schedule.

In expanding this ever-growing service, we have placed physicians on almost every interview program in the Chicago area. The bulk of our broadcast time, however, is compiled on programs produced or co-produced by ISMS itself. They include:

• *Medical Self Help Training*, an accredited, 15-week television course carried on station WTTW, Chicago. Medical Self Help Training is written and produced by ISMS and features Dr. Klinghoffer. The 30-minute weekly program, telecast at 9:30 Tuesday nights, began Feb. 22 and will continue through May 31. This is a re-telecast of the series carried in 1963-64.

• *Medical Interview*, a weekly five-minute discussion on timely medical topics, pre-taped for broadcast on 58 radio stations in Illinois. In the past 10 months—ending Mar. 31, 1965—this series has rolled up a total of more than 193 hours of air time. While production and distribution costs totaled \$4,500 during this period, Medical Interview has brought the society \$207,000 of broadcast time. This means that for every dollar invested here, ISMS received over \$46 in public service radio time.

• *Mal Bellair's Tie-Line*, a WBBM radio production for which ISMS is responsible for providing physician guests. Every Wednesday afternoon, an ISMS physician discusses common health problems and answers questions from listeners who telephone in. This is a 45-minute, weekly program. On alternating Monday afternoons, ISMS features a pediatrician on the Tie-Line program. This, too, is a 45-minute feature.

• *Dr. SIMS Health Tips*, a 30-second public service spot covered earlier in the report. It is carried by 59 Illinois radio stations. A similar version is taped by Dr. George Lull and aired over station WJJD.

• *Medically Speaking*, a weekly, 30-minute discussion show. This program was produced by ISMS and carried January through October, 1964, by Television Station WCIU.

• *Television Spots*, written, produced and distributed by ISMS. These include the one-minute Dr. SIMS measles spot and the 10-second spot announcements produced and distributed each month by our staff to support its outdoor advertising programming.

With our Medical Interview and Dr. SIMS Health Tips bringing in over \$700,000 worth of public service radio time alone, it is reasonable to assume that our total radio-TV services brought ISMS well over \$1,000,000 in broadcast time, an accomplishment of which the society should well be proud.

Outdoor Advertising

In July, 1964, your PR Committee launched an historic \$125,000 12-month campaign urging Illinois residents to protect themselves against the ravages of disease. It was historic because it marked the first time the medical profession utilized outdoor advertising.

Working with the Foster-Kleiser Co. of Chicago and 32 downstate outdoor advertisers, ISMS is promoting immunization, chest x-rays, and periodic physical examinations on 150 billboards through Illinois. The campaign—which covers a different

subject each month—began last summer with the theme, "Tetanus Kills, Immunize Today." Subsequent messages warned citizens against measles, tuberculosis, cancer, mental retardation, blindness, polio and diabetes.

While this campaign would normally cost about \$125,000 we are having the billboard space and artwork underwritten by the cooperating outdoor advertising firms. Printing of the posters is underwritten by various pharmaceutical companies and voluntary health agencies.

Participants—who have contributed \$1,200 each—include: Merck Sharp and Dohme, Illinois and Chicago Tuberculosis Associations, Illinois Council for Mentally Retarded Children, Illinois Society for the Prevention of Blindness, Illinois Division of the American Cancer Society, Lederle Laboratories and the Upjohn Pharmaceutical Co.

In support of our billboard message of the month, we also provide Illinois newspapers, radio and television stations with "tie-in" articles and spot announcements.

Transit Advertising: Another "First"

During the month of August, our preventive medicine campaign reached citizens "on the go" when car cards were placed in over 1,000 Chicago Transit Authority busses and subway trains. The transit advertising cards were replicas of the 150 billboard posters which proclaimed "Measles Criples and Kills, Immunize Today."

The vehicle advertising program—estimated at a cost of \$2,000—was provided free to the society by the CTA and the Merck Sharp and Dohme Pharmaceutical Co. which underwrote the printing costs. The utilization of transit advertising to tell our story marked another "first" for the medical profession.

Educational Campaign on Kerr-Mills

In October, 1964, the American Medical Association asked ISMS to cooperate in a \$32,500 statewide educational campaign on the Kerr-Mills program. The campaign was part of a national program designed to educate the public on the many health programs available for elderly persons unable to pay for their medical care. The entire promotion was underwritten by the AMA.

In addition to placing advertisements in 228 weekly and 63 daily newspapers throughout Illinois during the week of Oct. 11-18, we augmented the campaign with promotional news releases, educational materials for radio and television, and pamphlets. Theme of the campaign was "Health Opportunity Programs for the Elderly."

Eldercare Campaign

The PR Committee also played a leading role in the ISMS' \$250,000 informational campaign on the proposed Eldercare Program (HR 3727) launched in February. While complete details will be reported to the House of Delegates in May, here is a brief resume of what your committee did.

• Recognizing Congressional Districts 19-21-23 as the pivotal districts, we opened our advertising program on Feb. 15 with a concentrated radio campaign in that area. Effective 90-second commercials urging citizens to support Eldercare were produced and broadcast twice a day on 28 different stations throughout the campaign.

• This was followed up with a statewide newspaper advertising campaign. Beginning Feb. 24—and every second week thereafter—we published quarter-page advertisements in 105 daily and weekly newspapers urging citizens to write their congressmen in support of Eldercare. We also utilized 10 ethnic publications in an effort to reach the people.

• On Mar. 10, we had 183 billboards posted—83 in Chicago and 100 downstate—reminding citizens of the advantages of Eldercare. These billboards were posted for a 30-day period.

• On Mar. 15, we launched the television phase of our campaign, broadcasting 60-second commercials every day on 14 leading Illinois stations.

• In addition to radio, TV, newspapers and billboards, your committee produced and distributed ad reprints, posters, and buttons to physicians throughout the state.

Conclusion

During the past year, your committee is proud to have introduced four “firsts” in the field of medical public relations. Thanks to an understanding Board of Trustees, we are the first medical organization to create and use a corporate symbol . . . to utilize outdoor advertising . . . to take advantage of transit advertising . . . and to provide a health education column to school newspapers.

We feel that this—together with our expanded radio and television services and two educational campaigns on Kerr-Mills and Eldercare—has provided us with one of the most progressive public relations programs of any state medical society. While we can look back on the past year with a sense of accomplishment, it is important to recognize that we have only made a small dent in the public relations problems facing our profession. Much more remains to be done, and the committee is confident that with the continuing support of the Board of Trustees, this will be accomplished.

Leo P. A. Sweeney, *Chairman*

Matthew B. Eisele

Albert E. Steer

Andrew J. Brislen

Charles J. Weigel

COMMITTEE ON PUBLIC SAFETY PC-7

The reduction of mortality and morbidity resulting from vehicular accidents is the prime concern of the Committee on Public Safety. Activities now in progress or initiated during the past year are as follows:

(1) Development of a compendium on first aid and transportation of injured for ambulance

drivers, morticians, small-town police and sheriffs' personnel.

(2) Continuation of the analysis of vehicular crashes under the sponsorship of Cornell University Accident Crash Injury Research (ACIR) Project.

(3) Development of further legislation bearing upon safer driving, automobile design and related areas.

(4) Endorsement to continue driving safety programs in the high schools of Illinois.

Four legislative bills were formulated by the Committee which counsel has reviewed for constitutionality and have been approved by the Board of Directors. They are as follows:

I. Old H.B. 966 of the 73rd General Assembly which has these salient features:

A. The filing of an application for a driver's license shall constitute implied consent of the applicant to the use of any and all medical records of the applicant by the Illinois Department of Public Health.

B. No liability shall attach to any physician, clinic or hospital supplying information relative to the applicant's physical and/or mental condition upon receipt of a certification for information from the Department of Public Health.

C. The Department of Public Health—in cooperation with the Illinois State Medical Society—shall promulgate rules and regulations establishing standards and minimal physical and mental requirements for all vehicular drivers.

D. A Medical Review Board shall be created whose members will be appointed by the Illinois Director of Public Health, with recommendations from the Illinois State Medical Society.

E. The Medical Review Board shall make judgment on all mental and/or physical qualifications of licensees or applicants and can direct examination of these individuals by their personal physician or one designated by the Board.

F. All information remains confidential except as required for purposes of any hearing relating to a driver's license, and shall in no event be admissible as evidence in any civil or criminal proceedings.

II. Old Senate Bill 210 (73rd G.A.) Implied Consent Law. In essence this bill states that:

A. Any person who operates a motor vehicle in this state shall be determined to have given his consent to a chemical test of his breath, blood, urine or saliva for the purpose of determining the alcoholic content therein, and such test can be administered by any law enforcing officer who has reasonable grounds to believe that such person was driving while under the influence of intoxicating liquor.

B. Only a physician or individual directed by

such physician acting at the request of a law enforcing officer—may withdraw blood for the purpose of determining the alcoholic content therein.

C. No action shall come against any physician, hospital or clinic for the withdrawing of such blood for the determination of the chemical test.

III. Reduction of Blood Alcohol for Mandatory Intoxication. The present Illinois law states that one must have in his body 0.15 mgm. per cent alcohol for mandatory intoxication which carries automatic license revocation. It has been adequately demonstrated in this country and abroad that this level is much too high, and the bill asks that this figure be lowered to 0.10 mgm. per cent alcohol.

IV. Correlation of Blood Alcohol and Driver-Pedestrian Fatalities. This bill is an amendment to the Coroners' Act. The 1963 House of Delegates approved a cooperative study between the Illinois State Medical Society and the Illinois Department of Public Health for the relationship of blood alcohol and driver-pedestrian fatalities. On the average, there are 2,000 such fatalities in Illinois each year, and a controlled study extending over a year's time would establish significant statistical data for the correlation of alcohol and vehicular fatalities.

The present bill states that in cases of accidental death involving a motor vehicle in which the decedent was the operator of a motor vehicle or a pedestrian, the coroner shall require that a blood specimen be withdrawn from the body within 6 hours after death, this to be done by a physician or at the direction of a physician. Any person withdrawing blood—or any person making an examination of the blood under the terms of this Act—shall be immune from all liability, civil or criminal, that might otherwise be incurred or imposed.

SUB-COMMITTEE ON ENVIRONMENTAL HEALTH

The Sub-Committee on Environmental Health of the Public Safety Committee and the Environmental Health Committee of the Illinois State Medical Society closely parallel each other. After some study of the activities of the Environmental Health Committee, it is the opinion of the Sub-Committee Chairman that there are certain areas where our Committee should augment those of the State Committee on Environmental Health. These are as follows:

Pesticide Control

The Inter-Agency Committee established by Governor Kerner in 1963, in a series of meetings concluded that:

1. A Legislative Commission be established by

the 74th General Assembly to study further need for pesticide regulation. In view of the growing health hazard, which is being given wide circulation in many of the news media, it would seem that our Committee should endorse the recommendation for a Legislative Commission to study pesticide regulation.

2. The Sub-Committee would favor legalizing the Inter-Agency Committee by enactment of specific legislation during the 74th General Assembly.
3. The Sub-Committee has learned that the Department of Agriculture is preparing a bill to license and regulate custom sprayers, and that it further proposes to submit this bill for review and approval to the Inter-Agency Committee. Since the Department of Health is represented on this Committee, the Sub-Committee feels that this provides for the ISMS Environmental Health Committee an opportunity to exert its influence to see that a sound bill is presented.
4. If legislation should be presented from other sources pertaining to pesticide control, and if this proposed legislation should contain provisions which appear unsound to the ISMS Environmental Health Committee's conception of good legislation, it would seem advisable that legislation be drafted by the ISMS Environmental Health Committee and held in abeyance until needed.

Air Pollution

The Illinois State Health Department is making progress in carrying out the provisions of the Illinois Air Pollution Control law enacted in 1963. Significantly, the State Health Department has developed jointly with the State of Indiana a draft of legislation to create a Bi-State Air Pollution Agency. Efforts are also under-way to create a similar arrangement with the States of Iowa and Missouri. The Department will need an increase in the Air Pollution staff if this arm of the organization is to function properly.

Water Pollution

The United States Public Health Service has called an enforcement conference in Chicago for March 1965 to discuss Inter-State Water Pollution between the States of Indiana and Illinois. This is an old problem which involves many allegations of water pollution from industry and metropolitan sanitary districts. The necessity for continued vigilance in this area by the Public Safety Committee is mandatory.

The incident of stream pollution which occurred in Mattoon, Illinois, November 1963, as the result of a 5,000 gallon vat of cyanide being dumped into a sewer, subsequently affecting the water supply of Newton, Illinois, is documentary evidence of the entire water system of the town and adjacent area. There needs to be a continual vigilance and

enforcement of all rules and regulations regarding water pollution.

Solid Waste Disposal

The Sub-Committee endorses the State of Illinois Department of Public Health's continued effort to secure a state law to establish effective means of solid waste disposal. We believe that such a regulation should be under the Department of Public Health with full authority for enforcement resting with the Department of Public Health.

Edwin A. Lee, *Chairman*

SUB-COMMITTEE ON PEDIATRIC HAZARDS

The physicians of Illinois have been encouraged to mail or personally distribute to their patients the leaflet entitled "First Aid for Accidental Poisoning" developed by the Bureau of Hazardous Substances and Poison Control of the Illinois Department of Public Health. These are available in any quantity desired from the Springfield office.

Poison Control Centers in Illinois hospitals have been expanded to 90 during the past year. The Committee's counsel was sought and implemented in this life-saving effort.

Walter Plassman, *Chairman*

SUB-COMMITTEE ON TRAUMA

The Sub-committee on Trauma has given careful consideration to legislation suggestions with regard to the proper training of ambulance drivers in the areas of first aid and the operation of ambulances.

It is also recommended that an ordinance be adopted to regulate the licensing, inspection and operation of ambulances, to provide standards for the licensing of ambulances and of ambulance drivers, attendants and attendant-drivers; to provide for renewal and revocation of licenses, to require written records and reports, to provide for traffic regulation of ambulances, and to establish penalties for violation of its provisions.

Specific training courses in first aid should be prescribed for ambulance drivers before they are licensed as operators. This would insure maximum safety to the injured and also favorably affect the subsequent medical care. Before definite training courses are adopted we recommend such programs as inaugurated by the Trauma Committee of the American College of Surgeons and the Red Cross be examined.

George Irwin, *Chairman*

Committee members participated in the President's Conference on automobile safety in Springfield, and the National Conference on Medical Aspects of Driver Safety and Driver Licensing in Chicago sponsored by the American Medical Association, the American Association of Motor Vehicle Administrators, and the U.S. Public Health Service.

Committee members also appeared on numerous radio and TV programs discussing topics relating to safe driving, first aid in the home, and medicine in the out of doors.

The Committee expresses its gratitude to James R. Slawny, Harvey D. Zuckerberg and Thomas Elrod of the Public Relations Division for unusual diligence and extraordinary efforts in assisting this committee throughout the year.

Julius M. Kowalski, *Chairman*

James P. Campbell

Walter Plassman

James J. Callahan

Edward Press

George H. Irwin

Norman J. Rose

Edwin A. Lee

Franklin D. Yoder

Frank W. Newell

Auxiliary: Mrs. Preston S. Houk

COMMITTEE ON MEDICINE AND RELIGION PC-8

Since the primary purpose of the Medicine and Religion Committee is to initiate and coordinate activities on the local level through county societies, the Committee launched plans for a three-part program for 1965 including:

1. A statewide survey to determine which county societies have not as yet established medicine and religion committees.

2. A field service program to encourage and assist those county societies in the formation of medicine and religion committees.

3. Assist local medicine and religion committees in the implementation of their programs.

Unfortunately, our survey—conducted in March—revealed widespread indifference toward formation of medicine and religion committees or implementation of such activities on the local level. In fact, only 10 out of the 93 societies have established medicine and religion committees, while seven others have expressed interest in doing so with assistance from ISMS. The Committee will begin its field service work this spring, working principally with those 17 county societies which have expressed interest in medicine and religion programming.

Letters will be sent to these county societies requesting invitations to appear before their members. At that time, our Committee representatives—working closely with the American Medical Association's Medicine and Religion Division—will show the ISMS filmstrip "Not By Bread Alone, distribute literature and stress the importance of medicine-religion activities on the local level. If necessary, we will assist the county society in establishing a medicine and religion committee.

Because the medical-religious needs of patients are contingent, the major function of these new committees would be to encourage and arrange frequent small-group meetings between physicians and members of the clergy.

Also, because of the public's growing interest in

this area, the Committee is exploring the possibility of producing a 13-week radio series based on case studies of physician-patient-clergy relationships. The series, which would be made available to county medical societies, could be produced in cooperation with the local ministerial associations. Not only would this provide for a balanced program, but it would also serve to strengthen the bond between the medical profession and clergy in that area.

In an effort to stimulate membership interest, the Committee published a story in the *Illinois Medical Journal* pointing up common problems existing in the area of physician-patient-clergy relationship . . . and how they can be solved through medicine and religion committees. It is hoped that the article—which solicited case studies from ISMS members for publication—would be the first in a series of IMJ articles on the subject.

Joseph R. Mallory, *Chairman*

Charles W. Pfister

Hilliard M. Shair

Paul S. Rhoads

Auxiliary: Mrs. Matthew E. Uznanski

MEDICAL STUDENT LOAN FUND/RURAL HEALTH COMMITTEE PC-9

The responsibilities of this committee include the major function of administration of the Illinois Agricultural Association/ISMS Joint Medical Student Loan Fund.

During the past year, an attractive and descriptive brochure was developed to inform the interested public about the features of this program. Any of our members that are interested in learning more about this program or wishing to see a sample of this brochure should contact our Headquarters office.

On Nov. 13, 1965, the annual dinner-meeting with the medical student participants and wives, medical school faculty, and ISMS and IAA officials was held in Chicago at the University of Illinois Student Union. This meeting offers an opportunity to talk with the students, discuss their present needs and desires, and provide them with an after-dinner program directed towards their future medical practice environment. The meeting is always well-attended by the program participants and provides valuable follow-up during the student's medical school years.

Since its last annual report, this Committee met with fellow Loan Fund Board members of the Illinois Agricultural Association on Sept. 22, 1964, and Feb. 2-3, 1965.

The September, 1964 meeting was called to discuss the legal aspects of several of the students and doctors defaulting in one or more of the terms of their contracts. The future position of the program in regard to specialized medicine (a major

factor in these delinquencies) was extensively discussed.

The Board members discussed the possibility that the length of required time to remain in practice in a rural community is too long, and also the possibility that the penalty of \$5,000 for default this requirement is too great.

5-Year Requirement Studied

It was the final decision of the Board that the five-year requirement was not too long, considering that the sole purpose of the program is to try and influence these doctors to remain in the rural communities after the five years. Also, it was agreed that if the penalty for breaking the contract was any less, more participants would be likely to pay the penalty and leave the program. The \$5,000 penalty requirement was fixed originally in direct relationship to the five-years of practice requirement.

On Feb. 2, 1965, the Loan Fund Board held an evening business meeting to review the annual financial report of the First National Bank Trustee. Loan interest and principal delinquencies were studied and follow-up collection efforts assigned to various members of the Board and staff.

31 Applicants Interviewed

On Feb. 3, 1965, the Loan Fund Board interviewed and studied the qualifications of 31 applicants for recommendation to medical school in the fall of 1965. This number of applicants is on par with the 35 applicants interviewed in 1964 and 30 applicants in 1963. There are 10 positions set aside in each freshman class at the University of Illinois College of Medicine, to be filled by recommendations from the joint ISMS/IAA Board. Low cost, easy term loans of \$1,250 yearly (a maximum of \$5,000) are available to any participant under the program.

During the past year, ISMS and IAA legal counsel were invited to business meetings of the committee, providing valuable suggestions to make the committee's contract form more legally viable and sharpening our ability to reduce the potential for contract delinquency and violation.

Recent upgrading of the qualifications for membership in the American and Illinois Academy of General Practice, and the heightening interest of graduating interns in a General Practice (two-year) residency place new demands upon the committee to re-consider an extension of the time authorized by the contract between graduation from medical school and commencement of practice for the minimum of five years in a rural area. Certainly, a trend towards the upgrading of practice standards should not be resisted, purposefully or through inaction, by previously established policy of this committee.

At the present time there are approximately 121 program participants:

Completed contracts	25	
Doctors in first five years practice	40	
Interns or military service	25	
Medical School—		
Seniors	7	
Juniors	8	
Sophomores	5	
Freshmen	11	31
		<hr/> 121

The *total value* of the Student Loan Fund at Jan. 26, 1965, was \$202,409. Ownership with IAA is on a 50/50 basis. The assets of the fund at this date were:

\$ 45,000—U.S. Treasury bills
\$151,015—2% Student promissory notes
\$ 6,394—Cash

The trust fund received 2% interest *income* in 1964 amounting to \$5,104, including penalties of additional interest upon default of the contract terms. \$831 was received from investment in U.S. Treasury bills. The only *expense* of the fund in 1964 was \$1,368 for bank fees for administration, resulting in a trust fund surplus for the year totaling \$4,567.

The bank expends considerable efforts on the daily administration and bookkeeping for this account. Their excess of costs over fees is a public relations contribution towards the success of this community service program.

Jack Gibbs, *Chairman*

Thomas C. Bunting

Jacob E. Reisch

ADVISORY COMMITTEE TO STUDENT AMA PC-10

The ISMS Advisory Committee to the five Student AMA chapters in Illinois has embarked on the most ambitious program in its history. The committee's goal is to acquaint the more than 1,000 Illinois SAMA medical students with the principles of organized medicine and to assist them in the preparation for their professional careers.

As its most significant undertaking to date, the committee has launched plans to inaugurate the first annual SAMA Conference for chapter members and their wives on May 1 at the LaSalle Hotel, Chicago. The event is designed to give the academic communities of all five schools an opportunity to participate together in a learning session typical of many conducted for physicians by organized medicine each year.

The conference will be co-sponsored by the Illinois State and Chicago Medical Societies. Sessions will begin at 4:30 p.m. with an address on "The Physician as a Good Samaritan—Legal and Moral Aspects" by Edwin J. Holman of the American Medical Association's Law Department.

Wives Encouraged to Attend

Following will be an address on "Medical Decisions and Spiritual Considerations" by the Rev. Dr. Elam Davies of the Fourth Presbyterian Church.

The assemblage will adjourn for a social hour preceding dinner, to be followed by the banquet address on "Quackery" by Dr. Morris Fishbein.

Wives of the students have been encouraged to accompany their husbands from beginning-to-end of the program. More than 500 people are expected to attend the conference.

A similar event on a smaller scale already has given some indication of the success that might be expected from this first annual spring conference for SAMA students. ISMS sponsored a Northwestern SAMA chapter dinner-meeting Jan. 26 at Younker's Restaurant, Chicago, which was addressed by Hiram Sibley of the Chicago Hospital Planning Council. Northwestern SAMA reported that the affair resulted in an increase of 40 new members to its chapter.

Microscopes for Needy Students

In addition, the ISMS Advisory Committee is seeking ways to provide microscopes for needy SAMA students at Loyola University's Stritch College of Medicine. The committee has also instructed ISMS staff to investigate ways to promote a pool of second-hand textbooks which could be circulated among the SAMA students of all five medical schools. The Committee has also made it possible for various SAMA chapter communications to be published with the help of ISMS staff members and the use of ISMS printing facilities.

Another important undertaking by the Advisory Committee was to invite the SAMA chapters to submit the names of duly appointed delegates who would sit in on various ISMS committee meetings.

What's more, SAMA representatives have asked to receive sufficient quantities of the ISMS Public Affairs Newsletter for distribution among their student bodies so that they might be kept abreast of current developments in governmental health care issues. A total of 1,000 newsletters are being circulated at the Illinois medical schools.

Hilger Perry Jenkins, *Chairman*

Louis R. Limarzi

Maurice M. Hoeltgen

Ralph E. Dolkart

David B. Radner

PHYSICIANS PLACEMENT SERVICE PC-6A

The objectives of the Physicians Placement Service—now in its 20th year of operation—are twofold: (1) to assist physicians in finding desirable locations in which to practice; (2) to assist communities in finding physicians. Mrs. Robert Swanson has served as secretary of the service since its inception in 1945.

During the past year, the service has been directly responsible for placing 18 physicians, and it has assisted in the placement of several others. General practitioners were placed in Christopher, Carrollton, Greenfield, Galena, Maywood (2), Chicago, Havana (2), Crystal Lake, Rochelle and Morton. Specialists were situated in: Arlington Heights, Galesburg, Maywood (2), Joliet, University of Illinois Health Service and the Medical Department of Western Electric.

While the demand for physicians among rural communities has increased considerably, our total number of placements have dropped. This is especially discouraging since we have increased our efforts in this area. The decrease in placements is not just an Illinois problem, however, for the Physicians Placement Service of the American Medical Association points out that it is characteristic of a nation-wide trend.

During the past year, we have had a total of 886 physician-applicants on our mailing list. While 526 still receive our notices of openings, some 360 have been removed from our mailing list because they have either found suitable locations or have neglected to answer our followup letters.

Meanwhile we have publicized 364 opportunities for physicians. While 40 have been removed for various reasons, we continue to publish 324. The following is a tabulation of physician applicants and opportunities available as of Mar. 1, 1965.

SUPPLY AND DEMAND
OF APPLICANTS AND OPENINGS
(As of March 1, 1965)

<i>Specialties</i>	<i>Physician Applicants</i>	<i>Openings Listed</i>
General Practice	99	191*
Anesthesiology	29	2
Dermatology	17	3
Internal Medicine	58	23
Neurology	5	0
Neurological Surgery	1	3
Obstetrics-Gynecology	67	4
Ophthalmology	13	10
Orthopedic Surgery	28	3
Otolaryngology	5	13
Pathology	30	2
Pediatrics	14	31
Psychiatry	9	7
Radiology	28	1
Surgery	84	8
Urology	13	8
Miscellaneous	26	14
	526	323

*128 in solo practice
63 in associate practice

While the demand for GP's in rural communities continues to mount, the number of available GP's is steadily decreasing. On the other hand—while there are few requests for surgeons— we are deluged

with requests from surgeons who are seeking to relocate.

According to a report by Southern Illinois sociologist, Raymond Wakeley, the 31 counties of Southern Illinois are faced with a critical shortage of physicians. Mr. Wakeley, who claims the health of the public is in jeopardy, urges prompt training of more physicians in Illinois.

His report—published in the Dec. 27, 1964, issue of the Southern Illinoisan and several other newspapers—states that the 31 Southern counties have a combined population of 1,054,996 or 10.5% of the state's population. However, they have only 731 of the state's 12,677 licensed physicians or 5.8%.

The report further showed that Illinois has 795 persons, on the average, being served by each physician in the state. This compares with a figure of 742 recommended by a national Committee on the Costs of Medical Care some 30 years ago and still considered a national standard.

However, the 31 counties of Southern Illinois average 1,443 persons per physician—or nearly double the recommended number—Mr. Wakeley reports. During World War II, the War Manpower Commission set the maximum desirable ratio at 1,500 persons per effective physician, a ratio which could not be increased without jeopardizing public health.

Of the 731 licensed physicians in the 31 Southern Illinois counties, 31 are inactive or retired. Excluding these doctors, the population to doctors ratio increases to 1,507.

ISMS Trustees from these districts admit that the physician-patient ratio may be high, but point out that Mr. Wakeley's report does not take into consideration the fact that many patients are referred to Paducah, Evansville, Cape Girardeau or St. Louis for specialists' treatments. It is debatable, therefore, just how critical the physician shortage really is.

In recruiting physicians for these areas, our Placement Service publishes lists and descriptions of towns seeking physicians and biographies of physicians willing to relocate. In addition, we keep our Student Loan Fund program students informed on communities seeking physicians and, periodically, mail new books of openings to interns, servicemen and senior medical students throughout the state.

Unfortunately, this is not enough, as our physician shortage in Southern Illinois continues to exist. A major factor in preventing physicians from relocating in those areas is the low income among the employed people, making it difficult for the physician to make a living, according to Dr. Charles K. Wells, Trustee, Ninth District.

In view of the discouraging supply and demand—and our unsuccessful efforts to convince physicians to locate in Southern Illinois—we solicit advice from the House of Delegates in meeting the situation.



COMMITTEES ASSIGNED TO DIVISION OF LEGISLATION AND PUBLIC AFFAIRS

COMMITTEE ON ARCHIVES LC-1

As authorized by the House of Delegates, the Archives Committee has concerned itself with the formulation of plans for the establishment of an ISMS Medical Historical Museum in the Old State Capitol building in Springfield which is being reconstructed as a shrine to Abraham Lincoln by the State of Illinois.

The Illinois State Medical Society has been offered an area of the old Capitol building that is 35 feet 1 inch x 39 feet 9 inches; it was in this room that the Illinois State Medical Society was organized in 1850.

ISMS will be required to raise funds in the amount of \$85,000 as the pro-rated share in the restoration of the building and approximately \$115,000 for the creation of displays and exhibits. This total of \$200,000 will be a non-recurring item. After the museum is completed, the State of Illinois will maintain custodial and guide service. The purchase of perpetuity in a national historical museum will actually be relatively inexpensive compared with the medical museums of other states that have a continuing cost of operation.

Museum Consultant Engaged

ISMS Legal Counsel was directed by the Board of Trustees, as recommended by the Archives Committee, to prepare a contractual agreement that would be negotiated with the State for participation in the museum. This contract establishes the basis for ISMS participation and contains an escape clause which would permit the Illinois State Medical Society to cancel agreement any time up to June 30, 1965. If not done at this time, the agreement would become binding on ISMS.

To pursue the development of appropriate medical museum displays, the Committee engaged as a consultant Robert Larsen, a museum specialist with the State of Illinois.

Inasmuch as the entire museum will be a shrine for Abraham Lincoln, the medical historical exhibit will concentrate on the theme, "Lincoln and His Doctors," displaying the medical problems and achievements of that time in specific Lincoln-related incidents. The Committee foresees a chronological

display of exhibits focusing first on the milk sickness of the 1830's and continuing through other special medical events of Lincoln's time, concluding with the death bed scene.

Mr. Larsen is presently engaged in preparing the actual design of the museum and investigating sources of materials, products, talents, and skills which will be utilized in completing the proposed museum.

First Payment Due Sept. 1

Considering the financial time table established by the State of Illinois for ISMS participation which would require one-third of the \$85,000 pro-rated construction cost to be paid by September 1, 1965, one-third by September 1, 1966, and one-third by June 30, 1967, and the attendant exhibit and display costs, the Committee has undertaken an attempt to encourage one of the major drug houses or philanthropic organizations to contribute sufficient money to finance the ISMS Medical Historical Museum.

Previously, the 1964 House of Delegates adopted the unanimous recommendation of the Reference Committee that the Society:

- 1) approve plans for establishing a medical museum
- 2) engage a professional historian for appropriate research
- 3) commit itself to raise \$85,000 as the pro-rated share of reconstruction costs
- 4) secure additional monies required for the preparation and display of exhibits
- 5) raise the necessary monies without a dues increase to the membership

Your Committee is hopeful that complete financing of the museum project will be underwritten by an outside agency that will be acceptable to the House of Delegates. Further, the Committee realizes that this must be firmly established prior to the signing of a fixed contract with the State of Illinois for participation in the state museum.

The Archives Committee continues to rely on the guidance and suggestions of the Finance Committee in these matters.

Emmet F. Pearson, *Chairman*
Clifford E. Smith Leo Zimmerman

BENEVOLENCE COMMITTEE LC-2

The ISMS benevolence program proffered financial assistance to 38 eligible physicians, their wives and dependents in 1964. Between 35 and 38 beneficiaries received monthly benevolence funds from the state society. Fluctuations in case loads occur with Benevolence Committee approval of new recipients and a death or changed conditions of others. As of Dec. 31, 1964, 35 recipients received a monthly total of \$3,505.

In 1964, the Benevolence Committee considering increases in the cost of living, recommended that the maximum contribution be increased to \$200 per month for a recipient with minor dependents and increased to \$150 per month for a recipient without minor dependents. This recommendation was subsequently approved by the Board of Trustees.

The Committee then reassessed each benevolence case to equate the benevolence contribution to the financial need of the recipient. As a result of the reassessment, 22 recipients received increases totalling \$610 per month. These increases were effective December, 1964. The Committee did not raise any of the benevolence grants to the maximum established as the response to the physician voluntary contribution for benevolence was at the time an unknown quantity. Consequently, moderate increases were considered desirable to maintain the solvency of the benevolence program. The Committee will re-evaluate the benevolence program in the light of the voluntary contribution.

Beneficiaries of benevolence funds received a total of \$34,960 in the year ending Dec. 31, 1964. This was \$3,310 above the 1963 expenditure. The 1964 expenditure of \$34,960 was offset by income from membership dues (\$2) \$18,750; investment income of \$5,700; contributions from the Women's Auxiliary of \$6,840 and others of \$120—total income benevolence fund \$31,410. With an expenditure of \$34,960 and an income of \$31,410 the fund experienced a deficit of \$3,550.

The Committee feels that the income from the voluntary benevolence contribution will insure the solvency of the benevolence program by providing a financial foundation to sustain the program.

The Committee wishes to express its sincere appreciation to individual physicians and to the members of the Women's Auxiliary for their support and contributions to the benevolence fund, and to the Finance Committee and to the Board of Trustees for their guidance in this matter.

Keith H. Frankhauser, *Chairman*

John H. Steinkamp

Raleigh C. Oldfield

COMMITTEE ON LIAISON TO ILLINOIS DEPARTMENT OF REGISTRATION AND EDUCATION LC-3

The Committee has concerned itself with prob-

lems emanating from the physician-licensure-enforcement campaign of the Illinois Department of Registration and Education.

As an advisory body formed at the request of the former director of the Department of Registration and Education to consider mutual problems of physician licensing, the Committee continues contact with the Department of Registration and Education to keep fully informed of the department's activities; maintains liaison with the Medical Examining Committee to learn of its actions; and effects consultation with hospital associations to review ramifications of the problem.

The Committee realizes that the subject of physician licensing is one of great significance that affects many individuals and activities. Consequently, the Committee holds itself available to offer its advisory services as requested by the Director of Department of Registration and Education.

Jacob E. Reisch, *Chairman*

E. A. Piszczek

H. Close Hesseltine

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY LC-4

In 1964, the Impartial Medical Testimony program played a significantly greater role in the adjudication of personal injury cases. As a tool of judicial administration, authorized by Illinois Supreme Court Rule 17-2 and Federal Court Rule 20, IMT examinations enhanced the disposition of 34 personal injury cases—17 in each jurisdiction, federal and state. Seventeen in the Federal Court exceeded by eight the nine IMT examinations ordered in 1963; seventeen in the State Circuit Courts surpassed by four the thirteen ordered in 1963. All of the Federal judges (12) have invoked Rule 20 ordering IMT examinations; twenty circuit court judges have invoked Rule 17-2 since the inception of the program.

A review of IMT cases shows that approximately 75% are settled at pre-trial stage; 15% eventually go to trial; 10% are dismissed.

The effectiveness of impartial medical testimony at the pre-trial stage was recognized by Judge Charles Barrett's IMT Committee, which recommended in its report to the Illinois Judicial Conference that it (Rule 17-2) "should be invoked more widely at the pre-trial level than it has since adoption by the Supreme Court, effective September 5, 1961."

Working towards a more realistic utilization of IMT examinations by the courts, the Committee in 1964:

- 1) completed a survey of all IMT cases
- 2) compiled statistical data of the program
- 3) initiated periodic mailings to judges
- 4) met with federal judges who have used IMT examinations

- 5) met with Illinois circuit court judges who have used IMT examinations
- 6) maintained effective composition of IMT panels
- 7) planned seminars for IMT panelists
- 8) published quarterly newsletters
- 9) continued effective liaison with federal and state court administrators
- 10) provided IMT speakers for county and branch society meetings
- 11) scheduled IMT luncheon for ISMS Annual Meeting—Speaker: Ernest Friesen, Dean, National College of State Trial Judges.

The IMT Committee believes that these activities have resulted in the encouraging trends of increased IMT usage in 1964. It is hopeful that continuing programs will beget more appropriate IMT usage in the coming months.

Our IMT program received special recognition from Federal Judge Francis Van Dusen of Philadelphia, Pa., when he requested that an ISMS IMT panelist examine a plaintiff residing in Chicago who was involved in litigation in Philadelphia. The Medical Society cooperated with Judge Van Dusen and offered the services of an IMT panelist as requested. Judge Van Dusen responded by expressing his appreciation to the Society for the IMT participation. This out-of-state IMT request certainly reflects the nationally known effective character of the ISMS IMT program.

The Committee sincerely appreciates the services of those physicians who have participated in the program; those who are available for service; and all others who have in various ways contributed to the development of the program.

Clinton L. Compere, *Chairman*

Francis E. Bihss	Maurice D. Murfin
R. Gregory Green	Harry D. Nesmith
Roger A. Harvey	Leo P. A. Sweeney
Samuel A. Levison	Harold V. Voris

Consultant: Edmund F. Foley

Ex-officio: Frank J. Jirka, Jr.

COMMITTEE ON LABORATORY EVALUATION LC-5

Proposed Future Activities

The Committee proposes to undertake an aggressive educational campaign among the members of the medical profession to expand the utilization of existing accreditation programs for clinical laboratories and blood banks. There are no requests for action by the House of Delegates.

Activity of Past Year

This Committee has concerned itself with the clinical laboratory and blood bank situation in Illinois as revealed by the results of the Clinical Laboratory Registration Act and as analyzed by the Governor's Commission on Clinical Laboratories.

Legislation passed in the 73rd Illinois General Assembly required the registration of clinical laboratories and blood banks and authorized a Governor's Commission to study the problem area to submit recommendations to the Governor.

In pursuit of this study the Commission held public hearing in December at which representatives of the various organizations involved in the operation of clinical laboratories and blood banks participated.

The Illinois State Medical Society presented testimony at these hearings. Inasmuch as the Chairman of the Laboratory Evaluation Committee, Dr. James B. Hartney, is also a member of the Governor's Commission, Dr. Thomas DeGraffenreid, a member of the ISMS Laboratory Evaluation Committee, delivered the ISMS position statement.

The essence of the position is that the operation of a clinical laboratory or blood bank is considered the practice of medicine. Therefore, licensure legislation as recommended by some participating groups would be a duplication of present physician licensing and be wholly unjustified.

Meeting on Jan. 8 to review the testimony presented at the public hearings and to attempt to project the attitudes of the Governor's Commission regarding—possible legislation, the Committee strongly reaffirmed the existing position that the operation of clinical laboratories and blood banks is the practice of medicine.

At the date of writing of this report the Illinois Commission on Clinical Laboratories, Blood Banks and Blood Bank Depositories has not submitted its report and there is no information available as to the plans of the Commission for proposing specific legislation. The Commission's report due Mar. 1, 1965, will be the subject of a supplement to this report prepared when further information on the activities of the Commission are available.

A report of this Committee to the Board of Trustees, considered at the meeting of Sep. 20, 1964, led to adoption of a portion of the report of the Committee which calls for reaffirmation of the AMA House of Delegates stand on blood banking activities, as set forth in the Position Statement on Blood Banks adopted by the House of Delegates in September, 1963.

James B. Hartney, *Chairman*

Theodore Z. Polley	Jack Williams
John E. Maloney	Thomas P. DeGraffenreid

COMMITTEE ON LEGISLATION LC-6

The Committee has met on the Saturday afternoon preceding each meeting of the Board of Trustees. Several additional meetings have also been held. On each occasion a full report of the Committee's deliberations has been presented to the Board of Trustees. Significant actions of the Committee have been reported to the membership

via the monthly journal insert entitled the "Legislative Listening Post."

Over the summer months and up to the adjournment of the 88th Congress just prior to election, your Committee was deeply involved with various national issues which have their effect on medical care in Illinois. On such issues, the Committee works in conjunction with the AMA, maintaining close liaison with the members of the Illinois congressional delegation in support of a unified medical position. High on the priority list, was activity to defeat the King-Anderson Bill which died in conference committee with adjournment of the 88th Congress. To offset the need for this type of legislation, much time has been devoted to seeking improvements in the Kerr-Mills program in Illinois. Committee representatives met on numerous occasions with officials of the Public Aid Department to improve both the benefits and the administration. Assistance was given to Congressman Paul Findley of the 20th congressional district, in his Medical Care Referral Program. Under this program persons encountering difficulty in financing medical care have been helped with their problems (usually involved in one way or another with Public Aid).

Kerr-Mills Plagued by Red Tape

Despite the fact that many deserving cases have been helped under Kerr-Mills, the program continues to be plagued by administrative red-tape in certifying eligibility under a welfare-type of investigation. The required checking of resources and payment by children of the needy aged have caused considerable dissatisfaction with the program. The liberal landslide in the November Election, all but doomed the concept of family responsibility and a full investigation of ability to pay, if Kerr-Mills is to be retained as an offsetting factor to a direct federal program such as King-Anderson. Accordingly, in January, medicine revamped its position, and the Eldercare Program was launched. As of this writing, the outcome of the contest between Medicare and Eldercare is very much in doubt. Your Committee has been extensively engaged in this campaign through the implementation of the basic phases of the Eldercare campaign among each of the county medical societies. This includes congressional contacts, distribution of literature, letters to congress, medical speakers before civic groups and the marshalling of assistance from other groups. Other details of the overall campaign will be reported elsewhere.

Participants in Public Affairs

Throughout the year, the Committee has lent support to the program of the Public Affairs Committee. Committee members attended and actively participated in the Washington Public Affairs Conference in February. The chairman of the Committee, Dr. Siegel, represented the Society as an observer at the Republican National Convention and gave testimony before the Platform Commit-

tee, Dr. Frank Jirka, an ex-officio member of the Committee did likewise at the Democratic National Convention.

In addition to all of the activity connected with national issues, your Committee has had to deal with the convening of the 74th Illinois General Assembly in January. The results of the at-large election for the House of Representatives and the problems of redistricting, have made for a most unique situation. It is most likely that extreme partisan clashes will develop over the major issues of financing and reapportionment. With respect to partisanship, the Committee wishes to remind delegates and the general membership that bills of pure medical significance, do not generally become involved in party politics. The leadership is rarely called upon to take a position on these bills. Therefore it behooves the physicians not to engender partisan feelings by assuming this when discussing such legislation with lawmakers of their own party or more importantly, by refusing to discuss it with lawmakers of the opposing party. Members of both parties are equally capable and frequently introduce legislation which is not in the best interest of good health care. To offset this, your Committee's recommendation to employ staff identified with both sides of the aisle has been approved by the Board of Trustees and staff has been so employed.

Springfield Newsletter

Because of the need for writing this report well in advance of the annual meeting, it is impractical to cover specific pieces of legislation. During the legislative session, the Committee publishes a weekly newsletter entitled "On The Legislative Scene", emanating from the Springfield regional Office. Any physician who is interested in keeping current with the legislation in Springfield should notify the Springfield Office to be placed on this mailing list. State legislation is also summarized monthly in the special journal page previously referred to. An up-to-date listing of all pending bills will be presented in a supplemental report to the House of Delegates.

The most effective lobby for or against legislation is embodied in the contacts which doctors make with their legislators in their own home districts. To further this objective, every county medical society is urged to maintain a legislative committee which can be called upon to act, and to keep the local society informed on the issues. Since legislation is an on-going activity, requiring a broad background, your state committee strongly recommends that local county committees retain continuity from year to year, with perhaps a third of the membership rotating each year. Experience has shown that it is impractical to deal with an entirely new committee for each congress or each general assembly. Legislation and public affairs are related functions. For the physician to deal effectively with a lawmaker about legislation, he must

be concerned with the process by which the law-maker is elected to office. For special reasons, two separate committees are maintained for these functions at the state level. In contrast, at the county level a combination of the two functions under one joint committee, is recommended.

Two Legislative Conferences

The Committee has held two conferences on legislation during the year, one in November in Chicago and one in Springfield in late February. The Springfield conference was held in conjunction with the biennial reception and dinner for members of the general assembly. We were honored at the dinner this year by the presence of the governor. Approximately 175 out of the total of 500 who attended were physicians or physicians' wives.

The tempo of legislative activity increases with each passing year as government becomes more and more involved in the practice of medicine. The Committee wishes to express thanks to the many physicians and members of the auxiliary who have helped with the legislative program. We are particularly grateful to the auxiliary for their work on the Eldercare campaign, other committees of the Society which have aided in analyzing bills, the Board of Trustees, legal counsel and our staff. The entire effort is principally dependent upon the response from the county medical societies. Our deepest appreciation goes to the county legislative chairmen, their committees and the officers of the county medical societies.

V. P. Siegel, *Chairman*

J. Ernest Breed H. Close Hesselstine
George B. Callahan C. J. Jannings, III

Ex-Officio: Frank J. Jirka, Jr.
 Ralph N. Redmond
 Philip G. Thomsen

Auxiliary: Mrs. Fred C. Endres
 Mrs. John Van Phohaska
 Mrs. Eugene Vickery
 Mrs. Wilson West

Legal Counsel: John W. Neal
 Frank Pfeifer

MEDICAL LEGAL COMMITTEE LC-7

The Committee continues effective liaison with the counterpart committee on the Illinois Bar Association by meeting in joint session to discuss and resolve medical-legal problems of mutual concern.

The present discovery deposition procedure as established by rules of the Supreme Court was thoroughly explored to reveal conditions of abuse and excess which frequently occur in litigation. Corrective discovery procedure action, as recommended by the Chicago Neurological Society, was previously approved by the Board of Trustees of the Illinois State Medical Society. Learning of the existence and activity of the Supreme Court Rules

Committee, chaired by Owen Rall, which is presently considering revisions to existing Supreme Court rules, the Committee forwarded the resolution of the Chicago Neurological Society to Mr. Rall and his Committee for consideration. An acknowledgement was received from Mr. Rall's Committee thanking the Society for its interest in that phase of activity and indicating that the suggested revisions would be considered.

Interprofessional Code Reviewed

The Rules Committee of the Supreme Court in its report to the Illinois Judicial Conference stated that "the Committee has been considering the revision of discovery rules, particularly those relating to interrogatories; also considering many other suggestions which have been received. It now seems to me that the need for haste is outweighed by the desirability of doing a thorough going job on the rules."

The Medical-Legal Committee in a recent meeting with the committee of the Bar Association reviewed the Interprofessional Code that was developed several years ago. After a discussion of various items in the code, such as the payment of physician fees for medical examinations and reports, the committees concluded that, in the light of present practice, revisions and refinements are necessary to improve the effectiveness of the code for the medical and legal professions.

Medical Fees Considered

Concerning physicians' fees, it was emphasized that the patient is responsible for paying the medical service fee. The contingent medical fee is not valid. Lawyer payment of a medical service fee is prohibited by law and the Canons of Legal Ethics. The physician recourse for non-payment is to serve a lien. It was suggested that when the doctor prepares his medical report he include a request for payment for the service rendered. If the lawyer acknowledges the letter and so informs the physician that he will be paid, his response has been held by the court to be binding. Some lawyers have the patient or the lawyer's client sign an authorization agreement to pay physician's fees. First sentence of an example reads: "I, _____, hereby authorize and direct my attorney to pay from the proceeds of any recovery in my claim or litigation to _____, M.D., the unpaid balance of any reasonable charge for professional service and the treatment of injuries sustained by me on _____ and said payment is to include professional services rendered to date and those rendered to the time of settlement or other disposition of the claim or litigation for the treatment of injuries and fees for medical reports, consultations, depositions and court appearances. The final paragraph of the form reads: "I understand that this does not relieve me of any of my personal responsibility for all reasonable charges made by _____, M.D., whether there is or is not a

recovery obtained in my claim or litigation. Future meetings will re-write the Interprofessional Code to achieve a more satisfactory standard of professional interaction.

Malpractice Screening Panels

The committees noted the usage progress of the IMT program in the federal and state jurisdictions and expressed the thought that the progress reflected in the increased usage of IMT examinations and in the increasingly reliable medical testimony derived attests to the significant values inherent in the program.

The Committee discussed the subject of malpractice screening panels that are in operation in several areas. Action on this subject was deferred until the next meeting to obtain malpractice panel information being presented at the AMA-ABA Medical-Legal Conference. This information will contain a survey of existing screening plans, including evaluations of the plans. With this information the committees will further explore the adoption of a suitable plan for Illinois.

The Committee realizes the inestimable tangible and intangible value to both professions of medical-legal interaction and will continue to develop, through effective liaison, the harmonious climate necessary for the deposition of mutual medical-legal problems.

Luis V. Amador, *Chairman*

Clinton L. Compere

John Meyer

W. W. Dalitsch

George C. Turner

COMMITTEE ON NARCOTICS AND HAZARDOUS SUBSTANCES LC-8

The Committee has concerned itself with two major subject areas:

- 1) Narcotics problem
- 2) Poison control centers

With respect to the narcotics problem, the Committee has

1) studied narcotics addiction and traffic in Illinois in relation to the national problem attempting to define distinguishing features of the narcotics problem in Illinois to chart a course of positive action

2) reviewed recommendations of the President's Commission on the Narcotics Problem

3) discussed the narcotics report of the American Medical Association and other pertinent material

4) reviewed proposals of the New York Academy of Medicine

5) effected liaison with the Council for the Understanding and Rehabilitation of Addicts

6) recommended that the ISMS Board of Trustees pass a resolution to the effect that ISMS work in concert with "CURA" to alleviate the narcotics problem

7) reviewed legislation introduced into the 74th Illinois General Assembly and made appropriate recommendations:

- a) supported House Bill 1 as an added deterrent to the illegal sale of narcotic drugs, barbituates and amphetamines.
- b) supported HR 38 in principle, establishing a governor's commission to study the narcotics problem and recommended an amendment to include on the commission a physician nominated by the Illinois State Medical Society.
- c) HR 39—appropriation of 2½ million dollars for a narcotics hospital. The Committee disapproved this bill because jurisdiction was under the Department of Public Safety and it lacked specifics of program—rehabilitation, prevention, custodial. The Committee felt that additional monies could be used to improve existing institutional facilities for narcotic rehabilitation to care for the individual in an environment of total health care.

The Committee initiated liaison with "CURA" (Council for the Understanding and Rehabilitation of Addicts). This council, composed of civic leaders, physicians, social workers, lawyers and legislators, and chaired by Father Wheeler, Chaplain of the House of Correction, is attempting to establish community rehabilitative facilities for addicts. One primary objective is to create half-way houses for addicts providing the transition from institutional care to normal society living. The Committee was greatly impressed with the work of this council and urged the passage of a resolution by ISMS Board of Trustees effecting a close ISMS working relationship with "CURA" to reduce the severity of narcotics addiction.

The Committee, concerned with evident weaknesses in poison control facilities, surveyed existing poison control centers in Chicago and downstate Illinois to determine the degree of coverage, accessibility and type of facility (poison control library or medical service center). From the survey, the Committee concluded that there is an urgent need for additional coordination between applicable groups to successfully implement a program of effective poison control centers. The Committee is presently attempting through contact with poison control organizations to develop a more effective plan of communications to ensure availability of information and medical service. Information obtained as to the type of poison control facility (academic library or poison control center) would be published in the Illinois Medical Journal, with copies forwarded to hospitals, emergency rooms, police stations, and public service agencies.

Ross Schlich, *Chairman*

Earl H. Blair

George S. Schwerin

William U. McReynolds

Joseph S. Skom

Bertram B. Moss

David M. Slight

COMMITTEE ON OCCUPATIONAL HEALTH LC-9

The Occupational Health Committee continues to strive for an effective occupational health program for the state of Illinois.

Specific Committee accomplishments in 1964 include:

- 1) Encouraging the creation and operation of additional occupational health committees in component medical societies to foster community occupational health programs.

- 2) Distribution of occupational health material pertinent to establishing committees, their organization, scope and responsibility.

- 3) Offering of specialized occupational health material as required by local industrial conditions.

- 4) Development of an occupational health speakers roster—18 occupational health specialties available to present an extensive range of occupational health topics at medical society, management, and lay organization meetings.

- 5) Sponsoring the first occupational health section, Monday, May 17, 1965, 9:00 a.m.—11:30 a.m., as an integral part of the ISMS annual meeting.

In addition to the above, your chairman and staff, Paul Swarts, attended the AMA Conference on Occupational Health which included a special meeting of the occupational health chairmen of the state medical societies. This conference was particularly meaningful in presenting programs, activities and ideas that can be adopted to improve the effectiveness of occupational health in Illinois. The meeting of state occupational health chairmen concerned itself with the medical, legal and administrative problems encountered in workmen's compensation acts in the various states. In relating the workmen's compensation situation in Illinois to the activities in the other states, the Committee explored in depth the proposed program of the California Medical Society concerning workmen's compensation. The essence of this proposal creates a medical-administrative division within the Industrial Accidents Commission to have as its responsibilities the supervision of all aspects of compensation and the law relating to medical care, rehabilitative services, termination of disability, establishment of fees to be paid to physicians. Further, the Committee continues to study the bills introduced in the 74th Illinois General Assembly concerning the Workmen's Compensation Act, Occupational Disease Act and others pertaining to occupational health to achieve the most effective workmen's compensation act.

Edward C. Holmblad, *Chairman*

Milton H. Kroneberg

Arthur E. Sulek

Arthur S. J. Petersen

Chester R. Zeiss

PUBLIC AFFAIRS COMMITTEE LC-10

The Public Affairs Committee was created by

action of the Board of Trustees on Jan. 12, 1964, to seek the long-range solution to medicine's governmental problems through greater participation by members of the medical profession in public affairs. In the interim between the last annual meeting and the November election the Committee met periodically to plan and discuss materials and programs to educate and activate members of the ISMS to take a more active and effective role in the political process.

Each county society was urged to appoint a Public Affairs Committee to be responsible for participation at the county level, either as a separate entity or in conjunction with their Legislative Committee. Fifty-one county societies and all 15 branches of the Chicago Medical Society activated such committees during 1964.

County and State Activities

Activities of the state and county Public Affairs Committees included the following:

The Public Affairs Newsletter was published six times in 1964. The *Newsletter* will be published quarterly during 1965, a non-election year. This publication contains information about politics and government and is designed to be helpful to individual physicians participating in public affairs. It is mailed to the entire ISMS membership.

Voter Registration posters and information were prepared and distributed prior to Nov. 3, 1964, elections.

Candidate Interviewing Sessions and Receptions were arranged at both the state and county level to give members the opportunity to meet and evaluate candidates for public office in the November election.

Public Affairs Meetings were held by several county societies, with programs devoted to the political process. Each county medical society was encouraged to hold one such meeting during the year.

The First Annual Public Affairs Dinner, featuring an address by former-Congressman Walter Judd, M.D., attracted more than 350 physicians and wives during the 1964 ISMS Annual Meeting.

Attend Washington Conference

The Washington Public Affairs Conference was attended by nearly 90 ISMS members and wives on Feb. 2, 3 and 4, 1965. The Public Affairs Committee arranged the first day's program, which included an up-to-date briefing on medical legislation by the members of the AMA Washington staff; individual visits to congressmen; and an educational program featuring three Washington newsmen from Illinois newspapers, Congressman Frank Annunzio (D-Ill.) and Bob Wilson (R-Calif.), and Richard Armstrong, Executive Director of the Effective Citizens Organizations, a national public affairs group. The Annual ISMS Congressional Reception and Dinner, attended by 15 Illinois Congressmen, Gov. Otto Kerner and Congressman Tim Lee Carter, M.D., from Kentucky, was held that evening.

On Feb. 3 and 4, the Washington conferees participated in the U.S. Chamber of Commerce Fourth Annual Association Public Affairs Conference, which featured leading national figures discussing matters of importance to business and professional people.

Many of the ISMS delegation attended as official representatives of the county societies, which sponsored their participation.

1965 Public Affairs Program

In January, the Board of Trustees authorized a broad program of public affairs participation for the county societies during 1965, as recommended by the Committee.

This program, to be activated at the county level, consists of the following:

1. County Medical Society Public Affairs Meetings—A selection of motivational and educational programs will be made available for sponsorship by county societies, who will be urged to conduct one such program during 1965.

2. Report on Issues and Politics—County Public Affairs chairmen will be provided with information and encouraged to give a short report as a regular part of each county society meeting. This report includes the status of important state and national issues, how legislators voted on key bills, and news of other major events in politics and government.

3. "Operation Opinion Leader" (Downstate only)—Each county is urged to sponsor at least one meeting each year at which representatives of the medical profession and the leaders of other elements of a county may exchange views and ideas.

3A. "Operation Fireside" (Cook County only)—Open discussion sessions, conducted by experienced physician-discussion leaders, and held in physicians' homes. This is a means of introducing material on public affairs to physicians and their wives in an informal and social manner.

4. Cooperation and support of allied groups having programs compatible with medicine in the public affairs field. These groups include those outside the medical field, as well as those without the medical

family, such as IMPAC and AMPAC. The Public Affairs program provides the background in political education needed by physicians to participate effectively in politics.

Voluntary Contributions Urged

IMPAC, the Illinois Medical Political Action Committee, and AMPAC, the American Medical Political Action Committee, are the mechanisms through which physicians and their allies may participate directly in political action. IMPAC (which was endorsed by the 1961 ISMS House of Delegates, is by law a separate effort supported on a voluntary basis by individual financial participation, as distinguished from corporate medical society monies.

The introduction in the 89th Congress of so many new proposals for massive federal spending in the health field demands a greater sophistication on the part of physicians and their wives for participation in the political process. If the voice of medicine is to be heard in the halls where the laws are made, there must be a concern back in the district where the lawmakers are made. To aid in financing this program, the 1964 House of Delegates approved a \$20 Voluntary Contribution, of which \$5 is to be used for political education through the Public Affairs Committee, \$10 transferred to IMPAC for political action and the remaining \$5 to be used for benevolence. Your Committee wishes to urge every physician to participate in this minimal effort by making this voluntary contribution in conjunction with the regular dues assessment.

John A. Newkirk, *Chairman*

Walter C. Bornemeier

William W. Boswell

Donald E. Clark

Justin Fleischmann

Theodore Grevas

C. A. Hedberg

Edwin F. Hirsch

Paul H. Holinger

Ralph H. Kunststadter

W. Robert Maloney

John W. Ovitz, Jr.

Arthur D. Poppens

James D. Rogers

V. P. Siegel

Paul W. Sunderland

Eli Tobias

Lorin D. Whittaker

Francis W. Young

COMMITTEES ASSIGNED TO DIVISION OF ECONOMICS AND INSURANCE

COMMITTEE ON AGING EC-1

During the past year, emphasis has been placed on implementation of programs on aging at the district and county level. Attempts have been made to activate the district and county medical society committees. It was anticipated that an active pilot program would be well on its way in District I. Regrettably, our expectations have not been fulfilled in any of the districts and major emphasis

during the coming year must again be directed toward implementing these programs.

In September, the members of the Committee on Aging and five of the 10 chairmen of the district committees met to discuss plans and programs of the district and county medical society committees. The *Manual on Aging*, which had been prepared as a guide was reviewed and we were informed that it has been distributed to district chairmen, all county societies, as well as members of the Board of Trustees and other interested groups. The Com-

mittee again urged that more effective action be encouraged at county and district levels in implementing the programs proposed by the committee. Frequent, persistent follow up activity will be required by Committee members, district and county chairmen and staff. Successful implementation at county level will provide a most effective method of adequately informing local physicians in all problems and programs for the aging.

Pilot Program in District I

The chairman of the Committee on Aging in District I reports that he has scheduled a meeting of his district committee in March, 1965. This district has been selected by the Board of Trustees for a pilot program and it is hoped that intensive efforts will be made by the district chairman, members of his committee, and staff of the Illinois State Medical Society to implement this program as rapidly as possible. Activity in other districts will depend to a considerable extent on the success of the program in District I.

The Illinois Joint Council to Improve the Health Care of the Aged held one meeting during the year and elected Dr. Joseph Mallory, one of the Illinois State Medical Society representatives, as its president for the coming year. It is hoped that the Illinois Joint Council to Improve the Health Care of the Aged will become a more active and useful organization under the direction of Dr. Mallory.

The stroke film continues to attract interest. The film has been shown in Europe, Canada, and Mexico as well as in many states in this country. Continued sales occur. During 1965, the film has been shown at several regional meetings of the National Joint Council to Improve the Health Care of the Aged (Institute of Nursing Home Care).

Accreditation of Nursing Homes

The Illinois State Medical Society and the Committee on Aging support the action of the National Council for the Accreditation of Nursing Homes in its accreditation program. More than 30 nursing homes in Illinois have been accredited under this program.

The American Medical Association Committee on Aging, in cooperation with the state medical societies of Illinois, Indiana, Iowa, Kentucky, Minnesota, and Wisconsin, held a Conference on Aging and Long Term Care in Chicago on Feb. 5 and 6, 1965. The meeting was attended by most of the members of the Committee on Aging and by a number of officers and other members of the Illinois State Medical Society. Approximately 400 participated in this conference. Dr. Edward Piszczek, President of the Illinois State Medical Society extended greetings from our society. Other program participants included Dr. Edward E. Gordon, chairman of the Sub-committee on Stroke Rehabilitation, and Dr. Edward W. Cannady, chairman of the Committee on Aging. The program concerned all aspects of aging and long term care, including adult education, employment of older people, service to the commu-

nity, home care programs, dental care, homemaker services, nursing home care, Blue Cross and Blue Shield services, rehabilitation, and health insurance financing of long term care. Following the meeting, members of state committees on aging were invited to meet with the American Medical Association Committee on Aging to discuss the state programs. Our *Manual on Aging*, which had been prepared as a guide for district and county committees on aging, was enthusiastically received by the members of the AMA Committee on Aging, and a suggestion was made that the Manual be made available to other state and county medical societies.

Cooperation with Heart Association

The Stroke Committee of the Illinois Heart Association has proposed a stroke disease entity program and the cooperation and advice of the Committee on Aging has been requested. The Illinois Heart Association proposes to employ a stroke coordinator, who would work directly with a local stroke committee composed of representatives of county medical societies, local health departments, hospitals, nursing associations, and other interested groups.

Dr. Henry Ricketts is representing the Committee on the Nursing Care of the Chronically Ill and Aging Committee of the Illinois League for Nursing.

Mrs. Howard O. Lowy has represented the Woman's Auxiliary at meetings of the Committee on Aging and also attended the Conference on Aging and Long Term Care. Mrs. Lowy has communicated with county medical society auxiliaries regarding programs on aging and has urged their participation.

The committee continues to support the establishment of more home care programs throughout the state. It is hoped that Blue Cross will consider participation in these programs in Illinois as they are doing in Michigan, New York, and some other states.

The Committee desires to acknowledge the services of Walter Livingston, for his assistance and cooperation in the work of the committee.

Edward W. Cannady, <i>Chairman</i>	
Preston V. Dilts	Henry T. Ricketts
Edward E. Gordon	Lawrence J. Rossi
Ray C. Johnston	Martin H. Seifert
Joseph R. Mallory	Roger F. Sondag
Ernest G. McEwen	Thomas T. Tourlentes
Stuart K. Olson	Henry M. Wilson, Jr.

Auxiliary: Mrs. Howard O. Lowy

BLUE CROSS-BLUE SHIELD LIAISON COMMITTEE EC-2

The Blue Cross-Blue Shield Liaison Committee was established for the purpose of providing a formal line of communication among the three groups—the Illinois State Medical Society, Illinois Medical Service, and Illinois Hospital Corporation—

thereby keeping each group informed of ongoing and projected programs, changes in policy, and anticipated activities. The Committee is careful to avoid overlapping the activities of other state medical society committees.

The Committee has been informed of the Blue Cross board's approved new offering referred to as the "Group 75 Plan". The plan is being offered to groups of 15 or more when existing plans require renegotiation. The plan has a deductible feature of \$25 paid by the insured and a co-insurance feature of 25% also paid by the insured, each of which is not applicable to obstetrics.

Each of the respective groups filed a brief statement with the Committee setting forth its aims and purposes and ways in which members of its board were appointed.

It was brought to the attention of the Committee that the physician's Blue Shield manual is being revised for the first time since 1958 and is in its final stages of publication. The manual will indicate the schedule of benefits of Blue Shield contracts and will be made available to Illinois physicians.

Blue Cross-Blue Shield representatives attend hospital staff meetings when invited to do so and participate in open discussion on matters of mutual interest. Such representatives are available upon request from medical societies for meetings at the branch, county, and district level.

The Committee was informed that statistics will be forthcoming from Blue Cross and Blue Shield on utilization of hospital and medical services broken down by hospital length of stay, diagnosis, age distribution. It is hoped by the Committee that such information will provide greater insight into the economic use of the prepayment mechanism as a means of financing hospital and medical care.

The Committee is of the opinion that there is a great deal of misunderstanding between the differences of service benefit plan and an indemnity plan. Therefore, it recommends to the House of Delegates that an educational program be undertaken to inform the membership in such matters and on other important issues relevant to health insurance coverage.

Norris L Brookens, *Chairman*

Chairman, Committee on Medical Economics	
C. Elliott Bell	Maurice M. Hoeltgen
Chairman, Committee on Relative Value	Chairman, Committee on Prepayment Plans and Organizations

Daniel Ruge

Chairman, Committee on Medical Education

COMMITTEE ON DRUG MANUAL EC-3

The Committee on Drug Manual, following the 1964 meeting of the House of Delegates, has

worked continuously and intensively to refine the list of drugs contained in the manual before the Illinois Department of Public Aid published and distributed it in October, 1964. The drugs listed are taken to reflect prescribing habits of active participating physicians in the state of Illinois.

The activities of the Committee have been reported regularly to the State Medical Advisory Committee and to the Board of Trustees during the past year.

In keeping with the 1963 directive of the House of Delegates, the Committee has continued to work with the Department of Public Aid in an effort to keep the drug list effective and up to date.

Regulations for Requesting Drugs

Requests for drugs not listed in the manual must be made by the attending physician in accordance with the following regulation of the Illinois Department of Public Aid:

In very unusual circumstances the attending physician, after having tried drugs listed in the Drug Manual, may deem that a special drug not listed in the manual is essential for a patient. In this event, the physician may direct a written request to the Committee on Drug Manual setting forth the medical facts in the case and the case name and address of the recipient. The Committee will approve or disapprove the request and so notify the physician. If approval is given, the Department of Public Aid will be notified of such approval so payment for the medication may be authorized.

Following publication and distribution of the Drug Manual by the Department, the Committee reviewed and approved special requests made by physicians for drugs not listed in the manual. During the first three months the manual was in existence, the Committee reviewed numerous physician requests and evaluated the frequency with which a particular drug was requested. A complete and accurate record of drug requests and committee action, and a list of drugs approved are kept in the Society's headquarters.

Continued Use of Drugs

In reviewing requests by physicians, it was brought to the attention of the Committee that some patients required additional refills for drugs not listed in the manual. As a result, the Committee then recommended that it be a policy of the Department of Public Aid to allow the continued use of a specific drug *not listed in the manual* when requested by a prescribing physician and approved by the Drug Manual Committee, for as long as is necessary for that patient, and to so notify the physician.

While the manual includes a wide variety of items and is thought to list the drugs required in the everyday practice of medicine, the Committee does not look upon the Drug Manual as final. Experience and constructive criticism by the member-

ship has made it necessary to reevaluate the list of drugs in the manual. As a result, many hours of tedious study and examination by the Committee have been devoted to preparing a supplemental list of drugs subject to the approval of the Medical Advisory Committee and the Board of Trustees to be submitted to the Department of Public Aid for its approval, publication and distribution to participating physicians. Such a list is planned to be submitted to the Department of Public Aid in March, accompanied by a recommendation to the Department of Public Aid that it be reproduced and mailed to participating physicians in the state of Illinois. In so doing, the Committee feels that it is fulfilling its obligation to the House of Delegates and the membership in keeping the drug list effective and up to date.

78 Million Tax Dollars

The work of the Committee was originally undertaken to conserve tax dollars used for health care programs for public aid recipients. The Committee, in its effort to fulfill its task, examined numerous documents and analyzed data which aided the Committee in defining the magnitude of its undertaking and the problems with which it was confronted. The Committee wishes to call to the attention of the membership the fact that over 78 million tax dollars are being spent annually in the state of Illinois on health care for recipients of public aid. Of that amount, 38% is spent for hospital care; 31% for nursing home care; 13% for drugs; 9% for physicians' services; and 9% for all other services including dental, ambulance, spectacles, etc. The total welfare expenditures for health care since 1955 have more than doubled.

Welcome Suggestions from Membership

The Committee appreciates the cooperation it has received from the membership as a whole. It also appreciates the constructive criticisms which have assisted the Committee in revising the current list of drugs and formulating its recommendation to the Board of Trustees and to the Department of Public Aid. Without this assistance and cooperation from the membership the Committee's task would have been insurmountable.

The Committee welcomes suggestions and comments from the membership and hopes they continue. The Committee will be guided by sound therapeutic recommendations of the membership when making future revisions of the Drug Manual for consideration by the Illinois Department of Public Aid.

Representatives of the Committee have had the opportunity to appear before a meeting of Trustee District VIII; Madison, Knox and St. Clair County medical societies; and explain the events leading up to the development of the Drug Manual. Representatives of the Committee have made themselves available to meet with county medical societies when called upon to do so.

James A. Wetherly, *Chairman*
Robert C. Muehreke Theodore R. Van Dellen
Consultants: Theodore R. Sherrod
Louis Gdalmán, R.Ph.

COMMITTEE ON FEE SCHEDULES EC-4

Public Aid

The Committee on Fee Schedules met with a sub-committee on fees of the Medical Advisory Committee to the Illinois Department of Public Aid. The joint meeting was called to follow up on Resolutions 18 and 19 submitted to the 1964 House of Delegates by the Chicago Medical Society referring to payments to physicians for services rendered public aid recipients in Cook County and equal payment to physicians treating public aid recipients throughout the state.

The Committee reviewed the background and reasons why Cook County physicians are not currently reimbursed for services performed in the hospital for public aid recipients. The record indicates that the Chicago Medical Society, in 1933, voluntarily agreed with the Department of Public Aid to forego payment to physicians for treating public aid recipients in Cook County so that the monies could accrue to Cook County Hospital and be used to provide better physical and medical facilities for the recipients of that care. At that time almost all indigent patients of Cook County were provided medical care at Cook County Hospital.

Since 1953, the number of indigent patients at Cook County Hospital has increased so greatly that more and more private hospitals as well as teaching hospitals are providing in hospital care for welfare recipients. Private hospitals accepting welfare recipients are reimbursed by the Illinois Department of Public Aid.

The Committee unanimously agreed that physicians in Cook County ought to be reimbursed when treating welfare patients in the hospital on the same basis as Illinois physicians outside Cook County, and that this ought to be brought to the attention of Harold O. Swank, Director of the Illinois Department of Public Aid. Such recommendation was brought to the attention of the Board of Trustees and subsequent action is covered in detail in the report of the Medical Advisory Committee to the Illinois Department of Public Aid.

The Committee reviewed the schedule of allowances of the Illinois Department of Public Aid and other existing schedules of allowances used by public and voluntary organizations. It was the consensus of the Committee that the existing schedules compared favorably with one another and that negotiations for specific fee changes should be delayed until a more propitious time; that negotiations for fee changes should be broad rather than focus on a particular area of practice.

The Committee recommended to the Board of Trustees, and the Board concurred, to appoint a committee to study fees and request the Illinois Department of Public Aid to appoint a representative to such a committee to meet with representatives of the committee to study fees.

Veterans Administration

At the request of the Veterans Administration, the Committee on Fee Schedules met with them to discuss a new medical fee schedule based on the relative value principle.

The Veterans Administration fee schedule was last negotiated with the Illinois State Medical Society in 1958. The Veterans Administration proposed a two percent increase in fees for fiscal 1966. At the end of fiscal 1966, the Veterans Administration proposes negotiations with the state medical society for a higher conversion factor applied to the relative value units which would result in a 20% increase in payments to physicians treating veterans outside veterans' facilities.

The Committee informed the Veterans Administration that it is not authorized to act on their proposal; that the shortness of time did not allow for complete analysis of the proposed fee schedule; and that the schedule would have to be examined in greater detail before reporting to the Board of Trustees at a future meeting.

During fiscal 1963, the Veterans Administration spent a total of \$192,000 for physicians services in Illinois for service connected disabilities. One half of this expenditure went for psychiatric care.

Division of Vocational Rehabilitation

Early in 1964 the Committee met with the Division of Vocational Rehabilitation to discuss the division's fee schedule after receiving approval to do so from the Board of Trustees at its January meeting. No committee action was taken following the meeting with the Division of Vocational Rehabilitation as no specific request was made by them at that time. Regrettably, early in January a copy of the Division of Vocational Rehabilitation's fee schedule was received in the Headquarters Office in which it stated on page 1:

Joint Agreement. The revised medical and surgical fee schedule effective Jan. 1, 1965, was prepared in consultation between the Illinois State Medical Society and the Division of Vocational Rehabilitation . . .

The Committee promptly brought this incorrect statement to the attention of the Division of Vocational Rehabilitation, who agreed that it would be corrected before further distribution of the fee schedule was made. The Committee was informed that only a few copies of the fee schedule had been distributed and that this correction would be made before further distribution was made.

Medicare

For the twelve months ending Dec. 31, 1964, a

total of 6,544 military dependents in Illinois were served. Payments to physicians totaled \$561,706.31. A breakdown of the cases is as follows:

Obstetrical and maternity	3,090
Premature care	58
Normal Newborn Care	381
RH Factor, Babies (exchange transfusions)	19
General medical care	1,181
Fractures	129
Other bodily injuries	249
Gynecological surgery	198
Other general surgery	625
Anesthesia claims	614
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Total	6,544

The Illinois Medical Service (Chicago Blue Shield) continues as fiscal administrator handling administrative details of the program.

Department of Children and Family Services

The Committee met at the request of J. Keller Mack, M.D., Department of Children and Family Services, State of Illinois, who discussed the increase in the number of unwed mothers in the state of Illinois. Because of the increase, the Department of Children and Family Services has been asked to help in the medical care of these women and their babies when local agencies are unable to take care of the load. It was brought to the attention of the Committee that the amount of state money being spent for this purpose has increased to the point where the Department is seeking to set up a fee schedule for payments to physicians involved. No specific request was made by Dr. Mack and only preliminary discussions were undertaken. Dr. Mack indicated to the Committee that further discussions in the department will be necessary before a specific request is made of the Illinois State Medical Society.

Whereas fee schedules are necessarily variable and of a temporary nature, established to respond to a specific need at a particular time, the Committee is purposely exercising extreme caution when discussing fee schedules in view of pending federal medical legislation.

George F. Lull, *Chairman*

C. Elliott Bell

Franklin J. Moore

Maurice M. Hoeltgen

Carl F. Steinhoff

COMMITTEE ON HOSPITAL RELATIONS EC-5

The Sixth Annual Joint Conference, sponsored by the Illinois State Medical Society and the Illinois Hospital Association, was held in Chicago on Sept. 17, 1964. The timely topic of "The Cost of Hospital Care" was examined in depth by 300 registrants made up of hospital administrators, trustees

and chiefs of staff. The morning session was presided over by Noel G. Shaw, M.D., Illinois State Medical Society Co-Chairman and had as its main speakers Dr. C. Marshall Lee, Jr., AMA Commission on the Cost of Medical Care, Boston; Donald W. Cordes, Administrator, Iowa Methodist Hospital, Des Moines; William S. McNary, President, Michigan Hospital Service, Detroit; Hiram Sibley, Executive Director, Hospital Planning Council for Metropolitan Chicago, Chicago; and Jack A. L. Hahn, Executive Director, Methodist Hospital, Indianapolis.

The afternoon session was divided into eight workshops, each of which was moderated by experts in areas affecting hospital costs including public assistance; Blue Cross; commercial insurance; organized labor; legislature; hospital trustees; government hospitals; and industry.

The Committee is in the process of publishing and distributing the proceedings of the Sixth Annual Joint Conference to the participants and other interested individuals.

The Committee recommends that these proceedings also be made available to the participants of the forthcoming joint conference with the Hospital Association. Plans will be outlined for the Seventh Annual Joint Conference as soon as the two groups meet.

As these plans are developed, the Board of Trustees will be notified and if such are formulated before the May meeting of the House of Delegates a supplementary report will be filed.

The Committee is continuing to lend assistance to the Hospital Association in its efforts to accredit non-accredited hospitals. A few such hospitals still remain.

The Committee is aware of hospital emergency room problems which are being examined by another committee of the Society. The Hospital Relations Committee is hopeful that "emergency room service" becomes the topic for the 1965 Joint Conference.

The Committee recommends to the House of Delegates that it encourage county medical societies to appoint committees to serve as liaison with hospital representatives and to review problems of mutual concern.

Noel G. Shaw, *Chairman*

John A. Bowman

J. W. Buser

John M. Dorsey

Harlan English

Kenneth John Smith

N. A. Thompson

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS DEPARTMENT OF PUBLIC AID EC-6

Since the 1964 meeting of the House of Delegates, the Committee has met regularly on the Saturday preceding the Board of Trustees meet-

ings. In addition, the Committee has served in an advisory capacity to the Department of Public Aid through its sub-committees, such as those on Drug Manual, Ophthalmology, Anesthesiology, and Radiology, by communicating directly with members of the Committee for their recommendations on particular cases submitted to them during interim periods. The recommendation of each member and the case involved is reported at the subsequent meeting of the full Committee.

A resolution adopted by the 1964 House of Delegates concerned the payment of fees to physicians for services provided in hospitals for Illinois Department of Public Aid recipients in Cook County. In August, William E. Adams, M.D., Chairman of the Board of Trustees, wrote a letter to the Hon. Otto Kerner, Governor of Illinois, pressing for a uniform policy by the department which would allow uniform payments to physicians serving public aid recipients throughout the state, whether such services are given in the recipient's home, the physician's office, the hospital, or other institution. In the letter, it was pointed out that it was the opinion of the Advisory Committee that such a change in policy would not result in increased demand for hospital care but would provide Cook County recipient-patients with choice of physicians in hospitals and contribute to greater continuity of care rendered by the family physician, which is disrupted under the present policy.

Governor Kerner Responds

On Oct. 8, 1964, Governor Kerner responded to Dr. Adams' letter and stated in part:

In recognition of the changes that have taken place in recent years in hospital staffing practice, Mr. Swank, Director of the Department of Public Aid, is of the opinion that the Department should pay Cook County physicians for services in the hospitals in the same way physicians are reimbursed downstate. Director Swank does plan to provide for this in the next biennial appropriation, and I am in hearty accord.

The Committee was informed by Director Swank that he did include in his 1965-67 budget request payments for Cook County physicians for in hospital services. As yet the Committee has not been informed of the final outcome of this request.

From time to time the state committee is confronted with problems concerning the quantity and quality of medical care being provided by physicians to public assistance recipients. Under such circumstances the Department of Public Aid has found it necessary to utilize lay personnel in contacting physicians and examining their practices. Consequently, the Cook County Medical Advisory Committee recommended to the State Medical Advisory Committee that physicians be engaged on a part-time basis by the Department of Public Aid to go into the offices of physicians and review their practices when there is question about the care

provided public assistance recipients. The State Medical Advisory Committee concurred with the Chicago Medical Society at its meeting Sept. 19, 1964, and so recommended to Harold O. Swank, Director of the Illinois Department of Public Aid, that only physicians be used for such purposes; that such physicians be engaged by the Department of Public Aid in a consultative capacity; and that they be reimbursed for their services.

Drug Policy Discussion

At present the Committee is engaged in planning a program to take place Monday, May 17, from 9:00 to 11:00 a.m., at the Sherman House, designed to explain the administrative details of the care of the public aid recipients. The program will also include events leading up to the department's change in its drug policy, with the ultimate development of the Drug Manual. Program participants will consist of representatives from the Department of Public Aid who are in a position to explain the details of the program as it now exists.

In keeping with the directive of the House to meet with county medical advisory committees to disseminate current information pertaining to Department of Public Aid rules and regulations, representatives of the Medical Advisory Committee's sub-committee on Drug Manual on several occasions met with county medical societies, and appeared before a meeting of Trustee District VIII. These meetings will be reported in greater detail in a report of the Committee on Drug Manual.

Distribute Kerr-Mills Pamphlets

The House of Delegates can be reassured that the Medical Advisory Committee is composed of at least "two physicians having in their practice a substantial patient load of public aid patients per annum," in accordance with Resolution 64-17, adopted by the 1964 House of Delegates.

Over 70,000 brochures pertaining to the Kerr-Mills program in Illinois have been distributed and additional copies are available upon request to the state society office. The brochures are directed toward the lay public and have been distributed to physicians for their offices, hospital waiting rooms, and other private organizations. Since the beginning of the Kerr-Mills program in August 1961 through January 1965, 20,291 patients over 65 have received assistance, for a total federal and state expenditure of \$12,507,956.

At the July 18 meeting, the state committee was informed that the General Assembly had created a Board of Public Aid Commissioners, composed of seven members, to serve as a citizens advisory group to the Department of Public Aid. The Board will examine and evaluate policies and practices of the Department of Public Aid when directed to do so by the Governor or the General Assembly. It will also recommend to the Director of the Department of Public Aid, and to the Governor and General

Assembly, the enactment of such legislation as it may deem necessary to effectuate improvements in the public aid programs.

Fee Schedules to Be Studied

In view of recommendations by the House to review fees currently being paid by the Department of Public Aid, the Medical Advisory Committee appointed a sub-committee to meet with the Committee on Fee Schedules of the state society to study and evaluate the present fees for physicians' services. At the present time, no recommendation has been made to the Department of Public Aid on the subject of fees other than that previously reported with regard to payment of Cook County physicians. The matter is still under study by the respective committees and specific recommendations will be reported at a later date.

The Committee recommends that county medical advisory committees in meeting with officials of county departments of public aid make every effort to smooth the administrative machinery of public assistance programs when necessary. The Committee urges county advisory committees, as well as individual physicians, to submit to the state committee specific recommendations for the improvement of public aid programs. The Committee feels that such combined efforts will aid the Department of Public Aid as well as the state medical society.

The Committee wishes to express its appreciation for the cooperation of the Illinois Department of Public Aid's staff, under the directorship of Harold O. Swank, and his assistants, Mrs. Janet Kahlert and Miss Leslie Freeman.

Fred A. Tworoger, *Chairman*

Walter C. Bornemeier	George T. Mitchell
Charles Baldree	Robert C. Muehrcke
James R. Cooper	Frank B. Norbury
George J. Dickison	Frank P. Skaggs
Chauncey C. Maher, Jr.	John H. Steinkamp
Rex O. McMorris	R. Kent Swedlund

COMMITTEE ON MEDICAL ECONOMICS EC-7

Two principal areas of concern have occupied the Committee's attention since the 1964 meeting of the House of Delegates: (1) Retirement programs available to members of the Society; and (2) Group major medical coverage for members.

The Committee recommended (and the Board approved) retirement investment mechanisms for members of the Society which utilize a group annuity underwritten by the Continental Assurance Co. and a no-load open end mutual fund managed by Stein Roe Farnham of Chicago. A complete mailing went to each member of the Society in December, 1964, containing literature outlining in detail the provisions of the "Retirement-Investment Program" and "The Tax Qualified Program" (Keogh). Your Committee prepared and published

a report on the "Retirement Investment Program" in the *Illinois Medical Journal*, January, 1965, which explains its provisions in detail. Several physicians have enrolled in the program.

400 Expected to Enroll

A second mailing to the membership outlining the program was made in February, 1965. An additional 300-400 enrollees are expected before the open enrollment period closes for the "Retirement-Investment Program." The enrollment period for the "Tax Qualified Program" (Keogh) is continuous throughout the year.

Group Major Medical

Before the retirement programs were off the ground, the Committee began reviewing group major medical proposals in keeping with the action of the 1964 House of Delegates. After continuous and arduous work examining the various plans submitted, the Committee recommended that refinements be made and benefits broadened in the interests of the members before making its recommendation to the Board of Trustees. At the present time, the Committee has not yet formulated its recommendation to the Board regarding the major medical plan but hopes to do so at the Board's March meeting. If such a recommendation is made to the Board of Trustees and positive action taken before the meeting of the House in May, the Committee will file a supplementary report to the House.

Economic Newsletter Planned

The Committee is vitally interested in the economics of medical care from a broad point of view and the impact of economics on the medical care market. A vast amount of information and data are published regularly on the subject in scattered sources, both public and private. In view of this and the growing importance of the economics of medical care, the Committee plans as one of its projects for the forthcoming year to prepare and distribute an *Economic Newsletter* to the membership embodying economic information of importance to the membership.

Norris L Brookens, *Chairman*

Maurice M. Hoeltgen

Philip C. Lynch

John J. Holland

Clifton L. Reeder

F. Paul LaFata

Robert E. Schettler

Frederick Z. White

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS EC-8

Requests continue to be received for copies of the HIC Comb-1 Claim Form. These forms, provided in pads of 50, continue to be available without cost so long as the supply lasts. Requests

should be mailed to the Chicago office of the Illinois State Medical Society.

In keeping with the directive of the 1963 House of Delegates, the Committee recommended to representatives of the Health Insurance Council that the form be revised by clarifying what is wanted in the medical section; that release for medical information be included; and that the form allow for the assignment of benefits.

Representatives of the Health Insurance Council were contacted immediately following the 1963 House of Delegates which was reported to the House in 1964. After continuous refinements, the Health Insurance Council is now in the process of preparing a revised form incorporating most of the recommendations made to the Council.

Attends Health Insurance Congress

The Chairman of the Prepayment Plans and Organizations Committee was authorized by the Board of Trustees to attend the Fourth National Congress on Voluntary Health Insurance, Oct. 2-3, 1964. Immediately preceding that Congress, there was a meeting of the American Medical Association's Committee on Prepayment Plans and Organizations, which was also attended by your Chairman. At that meeting the new claim form was discussed and several suggestions made as to how it might be improved. It was agreed by the Health Insurance Council to include the name of the insurance company on the form; to provide an authorization to release information to be signed by the patient; and to provide an authorization for the insurance company to pay the physician. The forms will have a uniform layout, printed only on one side and marked with typewriter spacing.

Questions in the medical section will be kept at a minimum and will pertain to the diagnosis and nature of the sickness or injury or any other disease or infirmity affecting such condition.

Guide for Reviewing Cases

The Fourth National Congress on Voluntary Health Insurance explored the "Conservation of the Health Care Dollar" from the viewpoint of the consumer; management; labor; hospitals; Blue Cross-Blue Shield; independent plans; insurance; and physicians. Afternoon workshops reviewed the subject within the above frame of reference.

The Committee is in the process of developing a guide for the presentation of cases to the Committee for review. The guide, when completed, will include the Committee function, source of inquiry or complaint, procedure to follow, and committee action. The Committee is of the opinion that such a guide properly used will serve the Committee well when examining cases presented to it for action.

Maurice M. Hoeltgen, *Chairman*

Philip C. Lynch

H. Kenneth Scatcliff

Michael Saxon

E. Lee Strohl

COMMITTEE ON REHABILITATION SERVICES EC-9

The Committee on Rehabilitation Services is in the process of refining a booklet started last year listing available rehabilitation facilities in the state and types of disabilities amenable to rehabilitation. The Committee hopes to learn what rehabilitation facilities are available in hospitals and long term care institutions; how they are supervised; and by whom. In order to obtain such information, the Committee is developing a survey questionnaire to be mailed to hospitals and long term care institutions if such is approved by the Board of Trustees. The booklet, when complete, will contain valuable information to the members. At the present time this has been unavailable from a single source.

At its meeting Feb. 18, 1965, the Committee reviewed and endorsed H.B. 233, a bill before the Illinois General Assembly which would require plans and specifications in the erection of public buildings by the state or any of its political subdivisions to conform to the standards contained in the booklet entitled, "American Standard Specifications for Making Buildings and Facilities Accessible to and Usable By the Physically Handicapped." The action of the Committee was referred to the Legislative Committee of the Illinois State Medical Society for its consideration.

The Committee emphasizes the importance of rehabilitation services performed in qualified institutions and hospitals. The Committee again recommends to the House of Delegates that the insurance industry be urged to include rehabilitation services in their contracts and that this recommendation be brought to the attention of the appropriate committee of the Society for implementation.

The Committee recommends to the House of Delegates that the importance of rehabilitation medicine be brought to the attention of the county medical societies in an effort to activate programs oriented toward rehabilitation.

Edward L. Compere, *Chairman*

Paul Richard Allyn	Rex O. McMorris
Henry B. Betts	Robert Dunham Moore
Eli Borkon	Daniel Ruge

Howard W. Schneider

Consultant: Reuben R. Wasserman

Ex-Officio: Frank J. Jirka

COMMITTEE ON RELATIVE VALUE EC-10

Copies of the Relative Value Study have been distributed as directed by the House of Delegates during the annual meeting in May, 1964. The demand quickly exhausted the original supply and a second printing of 3,000 copies was authorized. A charge of one dollar has been made for copies distributed outside of the membership of the Illinois State Medical Society.

Recent events in the field of health insurance and on the political front have emphasized the increasing importance of valid and up-to-date information regarding fees for services rendered, and of the Relative Value Study as a medium for providing such information. Without such data, the medical profession has no authentic foundation from which to negotiate.

In an inflationary economy the fee structure of medical practice is continually changing. Therefore, if the Relative Value Study is to accurately reflect these changes it must be subjected to periodic revisions.

The original survey upon which the Illinois Study was based was conducted in September and October of 1961. By 1966 it will be obsolescent, if not obsolete.

The Relative Value Committee therefore strongly recommends that a general revision, based on a state-wide survey, be authorized for 1966.

The Committee is presently evaluating "spot checking" as a means for assembling data to be utilized for appraising the validity of the Relative Value Indexes presented in the existing Study, and for making minor revisions where indicated.

Should a decision be reached by the Committee before the meeting of the House, a supplementary report will be filed.

The chairman has participated in all meetings of the Fee Schedules Committee and the Blue Cross-Blue Shield Liaison Committee, with one exception. The deliberations of these committees have been both informative and stimulating, and have been helpful in defining the role of the Relative Value Study in future negotiations.

C. Elliott Bell, *Chairman*

Walter C. Bornemeier	Joseph G. Gustafson
John F. Eggers	Franklin J. Moore
R. Gregory Green	Max S. Sadove
Gershon K. Greening	Theodore J. Wachowski



COMMITTEES ASSIGNED TO DIVISION OF PUBLICATIONS AND SCIENTIFIC SERVICES

COMMITTEE ON SCIENTIFIC ASSEMBLY SC-1

The problems facing this Committee remain the same as in previous years: maintaining and increasing physician attendance, selling technical exhibits, attracting more good scientific exhibits, and programming the best possible meeting early.

The last mentioned constitutes the major problem and it affects some of the others. Our inability to obtain the section programs early makes it difficult to sell exhibits and to promote the meeting properly. As a means of obtaining programs on schedule, we recommend the following:

1. That any section which does not complete its program seven months prior to the convention forfeits its right to a meeting, and the Committee on Scientific Assembly will then schedule the program for that specialty.

To further assist in the matter of programming, we recommend that:

2. Since there are no sections as such, the method of electing section officers should be eliminated. Instead, we favor the appointment of section chairmen by the Board of Trustees from names submitted by the respective state speciality groups. We suggest that secretaries *not* be appointed but that if a chairman wants help he can select his own secretary. The chairman's tenure should be for five years.

The Committee is aware of the two surveys being conducted to obtain opinions from physicians and exhibitors concerning the merits of the ISMS meeting and possible changes and is wholly in accord with their purpose.

Attempts to have sections combine their meetings have been unsuccessful in the main although the Committee believes these multi-disciplinary meetings would be most successful.

The most common suggestion for improvement continues to be a merger with the Chicago Clinical Conference but the Committee prefers to await the poll of the ISMS membership before submitting a recommendation on this point.

Although the program for 1965 was very slow in completion, the Committee feels it is an excellent one and should attract good attendance.

The Chairman, now completing his term of office, wishes to thank the members of the Committee for their assistance during the last three years. He wishes also to express his appreciation for the implementation of the Committee's program performed by Al Boeck of the ISMS staff.

William M. Lees, *Chairman*

Louis D. Boshes	Chauncey C. Maher, Jr.
John B. Condon	Harold McGinnes
Richard A. DeWall	Robert G. Page
Robert T. Fox	Gordon L. Snider
J. Robert Thompson	

COMMITTEE ON SCIENTIFIC EXHIBITS SC-2

At the recommendation of the Committee, a registration fee of \$3.50 per front foot was charged scientific exhibitors in 1964, without any apparent effect on the number of exhibits.

Twenty-seven fine exhibits were entered with the following receiving awards:

Most Original Work

Gold Award

Pneumotoxes Cystoides Intestinalis
J. M. Coleman, D. F. Cooney, A. J. Carballo and
H. Dizadji

Silver Award

Adenomyomatosis of the Gallbladder
John P. Fotopoulos and Arthur R. Crampton

Bronze Awards

The Proper Care of Laboratory Animals
N. R. Brewer and N. J. Kantor

Post-Bulbar Duodenal Ulcer

William T. Meszaros, Hildegard Schorsch and
Franz Gampl

Mechanics of Breathing—Pneumatic and Electrical Analogue

Christen C. Rattenborg and Duncan A. Holaday

Exceptional Educational Value

Gold Award

Prevention of Stroke By Carotid and Vertebral Surgery

Hushang Javid, Ormand Julian, William Dye and James Hunter

Silver Award

The Difficult Patient

Jackson A. Smith and Lester H. Rudy

Bronze Awards

Seven Years' Progress in Psychotropic Medication

Veronica M. Pennington

Induced Thrombosis for Intracranial Aneurysms
Sean Mullen, G. Vailati, C. Reyes and A. Raimondi

The Normal Placenta

H. P. Friedman, S. E. Smith and M. W. Huffman

The continuous showing of movies was again a popular feature, with 11 finally accepted for showing.

Applications for the 1965 convention were somewhat slow in arriving but we should have as many as we did in 1964. The movie schedule of twelve films was completed early and should offer some excellent viewing.

Coye C. Mason, *Chairman*

Raymond Firfer

L. W. Peterson

Charles P. McCartney

Arkell M. Vaughn

W. H. Newcomb

Leo M. Zimmerman

COMMITTEE TO STUDY THE CONVENTION SC-3

After considering the basic problem of slow program completion by sections, which has a definite negative effect on exhibit sales and promotion effectiveness, the Committee makes the following recommendation:

1. That the trustees establish a ruling that any scientific section that does not have its program completed seven months prior to the convention will lose its right to a meeting and that the Committee on Scientific Assembly shall then plan the program in that specialty.

As a means of facilitating the work of the section officers, who head non-existent bodies, the following change in bylaws is recommended:

2. That the section officers *not* be elected by the sections (which are not formal bodies) but instead they be appointed by the trustees for a period of five years. It is suggested that each specialty group in the state submit two names as nominees for the chairmanship of the respective section and that the trustees select the chairman from these. There would be no secretary unless the chairman selected one to assist him.

The problem of schedule conflict among sections

is still acute, so the Committee recommends the following:

3. That the trustees urge sections to consider combining to present strong, multi-discipline meetings which approach a medical problem from two or more integrated specialty approaches.

The decline in technical exhibits and income led to speculation and discussion of the reasons for this in a state medical society with such a dynamic reputation.

In an effort to obtain information necessary to rebuild the technical exhibit portion of the convention, it is recommended:

4. That a survey be made of the major pharmaceutical and medical supply firms which do not exhibit at the ISMS convention to obtain their reasons for not selecting this meeting.

To further impress the firms who do exhibit with us, it is recommended:

5. That there be a formal opening of the exhibit hall at 11 a.m. on Monday, May 17, and that all officers and delegates be urged to attend the opening and visit the exhibits afterward.

A survey of 2,000 ISMS members will be made in the next few weeks to obtain opinions necessary to guide the Committee in its study of the convention and its problems.

George F. Lull, *Chairman*

E. Chester Bone

William M. Lees

Edwin S. Hamilton

H. Marchmont-Robinson

Norman Powers

COMMITTEE ON CANCER CONTROL SC-4

Report not available for publication.

CARDIOVASCULAR COMMITTEE SC-5

Report not available for publication.

COMMITTEE ON CHILD HEALTH SC-6

The Committee's activities for the year embraced a number of important subjects and satisfactory solutions were found for several problems.

In regard to the matter of aid to cystic fibrosis patients, a subject carried over from the previous year, the advice of Dr. Edward Lis was sought. Several possible courses of action were considered, always in full awareness of the consequences of any precedent-setting action applicable to other chronic disease factors.

Finally the Committee recommended that cystic fibrosis patients be included in the program of the University of Illinois Division of Services for Crippled Children in accordance with its usual program for handicapped children.

Having previously endorsed the principle of leg-

isolation on the Physically Abused Child, the Committee recommended that the Trustees of ISMS support the bill introduced by the Commission on Children. The Committee emphasized its support of the section which defined those persons required to report physical abuse cases, and opposed broadening the section to include non-medical personnel.

When confronted with the growing problem of the prescribing of oral polio vaccine to be administered by a pharmacist or parent, the Committee endorsed the position of the Illinois Chapter of the American Academy of Pediatrics which holds:

"Except for Community-wide programs, the Sabin oral polio vaccine should be given only in physicians' offices under the direct supervision of a responsible individual in that office; that this would insure the potency of the vaccine received by the patient and the safety factors needed to protect the community in the disposal of vaccine containers, and would provide continued supervision of the child's immunological status by a physician."

The basic School Health Records developed by a sub-committee received approval from the Illinois Department of Public Health, the Illinois Department of Public Instruction, the Illinois Chapter of the American Academy of Pediatrics, the Illinois Joint Committee on School Health, and ISMS. Although three other agencies had failed to respond to the request for approval, the sub-committee was instructed to proceed to get the forms into statewide use.

Opposition to a program of mandatory PKU testing was expressed by the Committee. The bill requiring mandatory testing was reviewed and rejected in favor of a voluntary plan based on Department of Public Health laboratories and regional laboratories. The Committee expressed the belief that 85% of the newborns could be screened if the need for testing were impressed on Illinois physicians and hospitals.

Dr. W. W. Fullerton represented the Committee as moderator of a panel at the Third Conference on Schools and Physicians in Springfield, Dec. 3, 1964. He also participated in a panel at the annual meeting of basketball coaches at the University of Illinois on Nov. 8.

Ralph Kunstadter, *Chairman*

Irving Abrams	Fred P. Long
Oliver Crawford	J. Keller Mack
Eugene F. Diamond	Franklin A. Munsey
R. E. Dukes	Kenneth S. Nolan
W. W. Fullerton	H. F. Philipsborn, Jr.
Edward Hess	William H. Schwingel
H. R. Hone	W. G. Steiner
Edward F. Lis	Norman T. Welford

W. M. Whitaker

COMMITTEE ON CONTINUING EDUCATION SC-7

Although the goal of a statewide coordinated

postgraduate program is still to be achieved, the demand for scientific speakers from the Illinois State Medical Society continued to grow during 1964. The evaluation of speakers was, for the most part, indicative of a successful operation on the part of the Scientific Speakers Bureau and certainly justified its existence.

The reaction of some of the speakers, however, required a modification of the system which placed the responsibility for obtaining the speaker on the local county medical society. ISMS still provides a roster of speakers and topics, pays the honorarium and expenses of the speakers, and mails the notices and publicity, but the component societies must contact the speakers and arrange the meetings.

This change did not affect those postgraduate programs which utilize several speakers. These are still arranged by the ISMS staff.

Despite the fact that no action was taken concerning the smaller counties where attendance is a problem, the Committee did suggest that insofar as is possible these societies combine for scientific meetings to present a larger audience for the speakers.

New Speakers Roster

Work was begun to produce a new edition of the Scientific Speakers Bureau Roster. This is scheduled for completion this spring for distribution to all counties. To facilitate the work of the program chairmen, addresses and phone numbers of all speakers will be included.

Again, the Committee expressed the belief that the honorarium should be increased to \$50 and so recommends to the House of Delegates. During the period Mar. 1, 1964, to Feb. 28, 1965, postgraduate courses were presented in Champaign County, Logan County and Bond County. Eleven speakers participated, 1,382 programs and postcards were printed and mailed out.

The decline in the number of postgraduate programs was disappointing, especially since the participants were so well received. It is hoped that the trustees will encourage the societies in their districts to take advantage of this service.

The number of counties served by the Speakers Bureau declined somewhat, but the number of speakers assigned increased slightly to 72. Again, all concerned are urged to take advantage of the bureau to support speakers for their meetings.

82 Physicians Participate

Counties receiving speakers were Bureau (6 speakers), Carroll (1), Clay (1), Clinton (1), Coles-Cumberland (4), DeKalb (4), JoDaviess (1), Kane (3), Knox (6), LaSalle (6), Livingston (9), Macon (2), McHenry (5), Montgomery (5), North Shore Branch-CMS (3), Rock Island (4), Stephenson (3), Vermilion (3), Whiteside (4). In addition, one speaker was provided for the program of the Southern Illinois Medical Association.

All in all 82 physicians participated in 24 coun-

ties, 1,382 programs were printed and distributed and 4,920 postcard notices were mailed.

The over-all evaluation of the activity was quite good. Merck Sharp & Dohme renewed its support with a check to the Educational & Scientific Foundation for \$4,000 in January of 1965.

Action Required: Request that the honorarium be increased to \$50.

Robert J. Freeark, *Chairman*

Hubert L. Allen	William M. Lees
Edwin N. Irons	Louis R. Limarzi
Leon O. Jacobson	Mather Pfeiffenberger
Ralph H. Kunstadter	Joseph H. Skom
Harold Laufman	James Weatherly

Hyman J. Zimmerman

Ex-Officio: William E. Adams

COMMITTEE ON ENVIRONMENTAL HEALTH SC-8

Fire Safety Standards for Wearing Apparel

In the area of flammable fabrics the Environmental Health Committee has worked jointly with the subcommittee on Environmental Health of the Public Safety Committee and directly with the Board of Trustees.

Last year a resolution encouraging physicians' participation in programs to prevent fires from flammable fabrics and recommending state legislation on the subject was passed. This year the Board of Trustees authorized drafting state legislation for submission to the 74th General Legislative Assembly in Springfield. The first draft of this legislation has already been drawn up by the chairman of the Environmental Health Committee with the assistance of the legal staff of the State Department of Public Health. It is currently being reviewed by the Division of Fire Prevention of the State Department of Public Safety inasmuch as this branch of state government has been selected as the one responsible for enforcing these fire safety standards.

Air Pollution

At the Feb. 16, 1965, meeting of the Environmental Health Committee the question of air pollution, particularly from the standpoint of exhausts from motor vehicles and the incomplete combustion of soft coal was raised by Dr. Kunstadter (through letter). There was some discussion of air pollution in general and the chairman summarized the intrastate and interstate air pollution activities carried on by the State Department of Public Health. The summary follows:

The Illinois Air Pollution Control Law was enacted by the 72nd General Assembly and approved by the Governor, Aug. 19, 1963. An appropriation of \$50,000 was made to the health department to implement this Bill for the bi-

ennium. Since the enactment of this bill, the department has employed one engineer, one chemist, one technician, and one sampler, and have developed a laboratory capability. The department has developed rules and regulations to control open burning and have held a series of public meetings on these rules as provided by the act. The State Health Department has also developed jointly with Indiana the draft of legislation to create a Bi-State Air Pollution Control Agency and it is expected that this legislation will be introduced into both the Illinois and Indiana legislatures during their current legislative session. The states of Iowa and Missouri have been approached proposing similar interstate agreements. Neither state has a statewide air pollution control law at this time, but a bill for this purpose was introduced into the Missouri legislature last week. Matching federal funds on a two-to-one basis in the amount of approximately \$80,000 have been made available to Illinois during the current calendar year. Additional state funds are going to be required if this important activity is continued. It will be necessary to materially increase the size of the air pollution staff if the Illinois Department of Public Health is to handle air pollution complaints and investigations on a statewide basis.

The chairman indicated that there was about \$300,000 of federal funds available to assist Illinois with its air pollution work on a two-for-one matching basis which would require the state to raise half that amount. This new total for the biennium would enable increased control activities to take place for the study of the role of solid fuels in air pollution as well as the role of the very large number of automobiles, trucks, busses, etc., in the Chicago metropolitan area. The incomplete combustion of petroleum products in these motor vehicles substantially increases the potential hazards from air pollution.

The Committee submits the following:

RESOLUTION

WHEREAS, our modern industrial technology is continually increasing the potential numbers and types of particulate and gaseous products liberated into the atmosphere, and

WHEREAS, the industrial automotive fuel and heating sources of these Atmospheric contaminants are greatly concentrated and increased in large metropolitan centers and

WHEREAS, evidence for adverse health effects of these and other contaminants is accumulating at a continually increasing rate, and

WHEREAS, the Illinois State Medical Society is interested in and concerned with the potential adverse effects on health of these and other atmospheric pollutants,

NOW THEREFORE BE IT RESOLVED THAT, the Illinois State Medical Society urge the Governor of Illinois and State and Local Air Pollution

Agencies and Political Jurisdictions to intensify and expand their efforts in the field of air pollution.

BE IT FURTHER RESOLVED THAT, the Illinois Medical Society through their individual members, pertinent committees and staff, express their willingness to aid and cooperate in community and individual control methods.

Water Pollution

The problem of water pollution was summarized as follows in the Feb. 9, 1965, memorandum by the chairman to the members of the Environmental Health Committee:

On Mar. 2, 1965, the U.S. Public Health Service has called an enforcement conference in Chicago pertaining to pollution of interstate waters between Indiana and Illinois. These waters include primarily, Lake Michigan, the Grand Calumet, and the Little Calumet. Pollution is being alleged from Illinois to Lake Michigan at times of reversal of flow of the Grand Calumet primarily from industrial sources within the Metropolitan Sanitary District. Pollution is also alleged to flow from Indiana industries and municipalities into Lake Michigan and directly from Indiana into Illinois through the Grand Calumet and the Little Calumet. The conferees at this enforcement meeting will be the States of Indiana and Illinois and the U.S. Public Health Service. As a matter of general interest, during the months of June through Nov., 1964, the Illinois Department of Public Health collected 677 samples from the streams of Illinois for analysis of synthetic detergent content; 620 of the samples, or 91.6% had less than 1.0 ppm. of synthetic detergent.

Because of the importance of avoiding water pollution and the potential impact of such pollution on the safety of waters for drinking and swimming a resolution was proposed at the Jan. 17, 1965, meeting of the Illinois State Medical Society Board of Trustees. This resolution was passed unanimously by the Board and was transmitted to the chairman of the Conference on Interstate Water Pollution called by the United States Public Health Service.

Both the American Medical Association and the Illinois State Medical Society have been very much concerned about Senate Bill No. 4 of the 89th Congress in Washington to amend the Federal Water Pollution Control Act. This amendment would remove the water pollution control enforcement authority from the United States Public Health Service where it is under medical and health supervision and place it in a separate water pollution control administration that would have additional orientation in industrial, agricultural, and recreational utilization of water.

Health Hazards From Pigeons

Dr. Kunstadter, in a letter, raised the problem of the environmental hazards from pigeons. This was read at the Feb. 16 meeting and the possibility

of developing an informational and policy statement on this subject was discussed. It was agreed that the development of such a statement either through a subcommittee or through one of the committee members would be explored and when developed it would be circulated to the committee for comment and discussion.

Pesticide Control Legislation

A brief summary of the discussions of the Inter-agency Committee appointed by Governor Kerner in 1963 was given. One of the recommendations of this Committee was for the preparation of state legislation to license and regulate custom sprayers of insecticides and other pesticides. When this proposed bill is available it will be distributed to Committee members for their comment and discussion.

Food Poisoning Control Measures

There was some discussion of the current status of control programs and responsibility of the State Department of Agriculture and Public Health in this field. In summary, the State Health Department has jurisdiction of Grade A milk and milk products for licensing and regulation. However, other foods are under the supervision, inspection, and licensure of the Department of Agriculture. Should these other foods serve as a source of food poisoning or food infection, the State Health Department is charged with the responsibility of investigation and prevention.

Edward Press, *Chairman*

Robert J. Maganini	James B. Hartney
Milton J. Kronenberg	Ross A. Schlich
Franklin D. Yoder	Edward C. Holmblad
Ralph H. Kunstadter	Howard C. Burkhead

THE COMMITTEE ON EYE HEALTH SC-9

The Committee on Eye Health serves as a source of information for the Illinois State Medical Society on matters concerned with eye health. The Committee evaluates and makes available information and recommendations to the Board of Trustees concerning the position the Illinois State Medical Society should take on matters in this area.

It is the purpose of the Committee on Eye Health to assist in providing the citizens of the state of Illinois with the most modern and expert diagnostic and therapeutic resources possible for the management of abnormalities, diseases, and variations in refraction of the eye. The Committee has liaison with the Chicago Ophthalmological Society and the Central Illinois Society of Ophthalmology and Otolaryngology. It maintains familiarity with the scientific, sociological, and legislative activities which involve vision and the care of the eyes.

Interest in Legislation

The Committee has a particular interest con-

cerning legislative proposals in a variety of fields. In a number of states in recent years there have been legislative attempts to curtail the practice of medicine or extend the scope of limited practitioners in the field of ophthalmology. It has a particular interest regarding legislative proposals concerning ancillary personnel who provide paramedical technical services involved in the diagnosis of ophthalmic disorders, or are involved in the provision of ophthalmic appliances. The Committee has an interest in legislation concerning the licensure of individuals for the operation of motor vehicles and particularly that dealing with the relation of reduced vision to licensability.

Vision Testing Programs

The Committee is concerned with the organization, methods and results of vision testing programs in the primary and secondary schools. It has a similar interest in the development of effective vision testing methods for preschool children inasmuch as reduced vision from failure to use the eye (amblyopia ex anopsia) must be corrected prior to the child's entering school. The Committee has an interest in legislative proposals relating to the use of safety lenses in hazardous occupations including elementary and high school science laboratories and shops. The Committee is interested in continuing the present legislation aimed at preventing ophthalmia neonatorum as a cause of blindness.

It is the purpose of the Committee to cooperate with voluntary and governmental health agencies in providing information on topics relating to the eye, to the profession, and to the public. The Committee maintains a vigilance for misleading information and programs which need correction for the protection of the public.

Frank W. Newell, *Chairman*

Peter C. Kronfeld

Manuel Stillerman

Walter D. Stevenson

M. Byron Weisbaum

MATERNAL WELFARE COMMITTEE SC-10

The Maternal Welfare Committee has held four meetings since the report was last submitted to you, and one more meeting will be necessary before the backlog of 1964 cases has been completely eliminated. Your chairman notes with regret the loss of Dr. A. B. Owen, Dr. George Rezek, Dr. J. B. Waller, Dr. C. K. Wells who for various reasons are no longer serving as members of this committee. We were privileged to welcome Dr. Richard F. Whitlock, Dr. Charles P. Gaetano, Dr. Paul Raber and Dr. Harry L. Lewis. Dr. Owen was the ranking member of the committee in terms of years of service, and his absence is particularly missed.

In spite of the changing complexion of the committee, the pattern of discussion has remained ap-

proximately the same as that initiated by Dr. Falls. However, during the past year, in an effort to make our study more easily comparable with those conducted in other areas, all cases have been coded in strict conformity to the Guide for Maternal Death Studies prepared by the Committee on Maternal and Child Health of the Council on Medical Service of the American Medical Association.

Joint Committee on Perinatal Mortality

Your chairman has participated in several meetings with the chairman of the American Association of Maternal and Child Health as well as a joint committee on Perinatal Mortality of the Illinois State Medical Society. As a result of these deliberations, a program is being developed to codify all maternal deaths in an essentially similar fashion here in Illinois. In addition, we are developing report forms to aid in the study and classification of both maternal and perinatal deaths.

The relationship between your committee and the Illinois Department of Public Health has been and continues to be the close one which your chairman has found most helpful and he trusts a reciprocal feeling exists in the Department.

An increased number of deaths was investigated by your committee during the past year, but there has been no essential change in the maternal mortality rate. Of considerable satisfaction to your chairman has been the increased interest in the findings of the committee as evidenced by the fact that six physicians took time from their busy practices to present findings of their cases in person and to aid us in our deliberation; and of the remaining 59 cases, 25 confidential reports were mailed to interested physicians who wrote your chairman regarding the findings of the committee. When one considers the facts that of the 65 cases so far reviewed this year, 12 involved deaths at Cook County Hospital where the Chief of Service and the resident staff were present at our discussions, and some 23 cases were obviously non-obstetric, this indicates a very high order of interest in the work of this group.

Appeals for Advice

In addition to the analysis of protocols, the attention of the committee was occupied by appeals for advice or decisions in widely differing areas ranging from action requested relative to the setting of obstetrical fees under the Public Aid Program through methods of publicizing the work of the committee, the opinion of the committee relative to amniocentesis and to the presence of the father in the delivery room, the need for modification of the law in regard to therapeutic abortion on through such items as publicizing the use of the Apgar rating chart in determining the clinical status of the newborn.

Your chairman trusts that the other members of

the committee have been helped as much as he by these valuable discussions. Your committee would be remiss if it failed to again comment on the tremendous value of the efforts of Dr. Santos at Cook County Hospital in the presentation of salient pathological features present in the deaths that occurred in that institution. Dr. Santos and his staff have made a significant contribution to the understanding of many of the problems with which your committee has been confronted.

The cooperation of the individual members has been outstanding. It should be noted that on the two occasions when the current committee has met, only three delegates or alternates have not been present.

It is the hope of your chairman that the coming year will see a greater utilization of the facts solicited by this group and that Illinois shall continue to maintain its enviable position as regards maternal mortality.

Robert R. Hartman, *Chairman*

F. H. Falls, *Chairman Emeritus*

Richard F. Whitlock	Paul Raber
William J. Farley	Ray E. Bucher
Charles P. Gaetano	Harry L. Lewis
V. B. Adams	Barry V. Rife
William W. Curtis	Joseph R. O'Donnell

Ex-Officio: Willard C. Scrivner

Consultants: John H. Rendok

Franklin D. Yoder

Augusta Webster

Mila Pierce

Donaldson F. Rawlings

COMMITTEE ON MEDICAL EDUCATION SC-11

The highlights of each year for this Committee is the ceremony at the House of Delegates meeting where the AMA-ERF checks are presented to the Illinois medical schools.

This ceremony took place on May 17, 1964, with Dr. Daniel S. Kushner, Dean of Chicago Medical School receiving checks on behalf of the five medical schools. The following checks were presented:

Chicago Medical School	\$20,683.41
University of Chicago	19,206.00
University of Illinois	31,764.41
Northwestern University	34,771.00
Loyola University	26,095.41

These funds, plus grants to other medical schools designated by the individual physicians, are made possible by a \$20 per member contribution by each Illinois physician. They are unrestricted and can be used for any purpose.

There were no matters referred to the Committee during the year so meetings were not necessary. The chairman, however, did attend the AMA Congress on Medical Education, in Chicago in February.

Daniel Ruge, *Chairman*

Herschel Browns

Donald H. Dexter

Mather Pfeiffenberger

C. L. Reeder

COMMITTEE ON MENTAL HEALTH SC-12

Activities in the field of mental health were varied, touching on issues in several areas.

Early in the year, a meeting was arranged by the chairman with the Psychologists Examining Committee set up under the Psychologists Registration Act of 1963. Our intent was to emphasize our concern in the area of the "counseling" activities of psychologists in private practice, clarifying possible abuse and dangers. The meeting was cordial. The Examining Committee expressed its wish to cooperate in enforcing conscientiously ethical provisions which are incorporated in the act.

During the recent political campaign, a number of public statements were made by office-seekers regarding the program of the Department of Mental Health. This Committee felt concerned about possible misunderstandings and the loss of public confidence as well as the possible use of this medical issue as a "political football". Dr. Visotsky, Director of the Department, had prepared a progress report of its activities for the Society. In order to indicate the considered opinion of this Committee and to help remove the matter from the political arena, a non-partisan statement of our review of the program was prepared and published, along with Dr. Visotsky's report, in the November issue of the Illinois Medical Journal.

Congress on Mental Health

Several members of the Committee were active participants in the 2nd AMA Congress on Mental Health, some in the capacity of section leaders. The theme of this Congress was on action at the *community* level, with emphasis upon the role of the *non-psychiatric* physician. It is clear that this stress is appropriate and should be the major focus of planning. Along this line it should be noted that Dr. Arthur Baker of Waukegan, a member of this Committee, has been appointed by the Society as its representative on the Advisory Council of Professional Societies to the Planning Board of the Department of Mental Health. A second Committee member sits also on this Council (having been appointed in another capacity). The planning board with its several advisory councils is responsible for advising the Department and its director on practical implementation of community oriented mental health programs throughout the State.

Association for Mental Health

The Committee has maintained an active informal liaison with the Illinois Association for Mental Health in order to maintain a friendly cooperative relationship with this lay organization which has considerable influence in the community. In January, Dr. Albert Rauh of Springfield, a member of the Committee, attended the meeting of the Legislative Committee of that association. This meeting was concerned primarily with two proposed bills of current importance. One is concerned with increased provisions for education of the rehabilitable mentally retarded. The second consists of amendments to the Mental Health Code of 1964. Since the code went into effect in July, we have been observing carefully its effect, and particularly the practicalities of its implementation. At present it seems that certain changes would be desirable although the Code does provide a number of improvements. An overall review of this matter and preparation of concrete suggestions for changes will constitute the next order of business of the Committee in the coming period.

Donald Oken, *Chairman*

Arthur G. Baker	Harry D. Nesmith
Walter H. Baer	Harry Phillips
Louis D. Boshes	Albert Ruah
Irving Frank	F. L. Sullivan
Richard J. Graff	

Consultant: Harold M. Visotsky
Auxiliary: Mrs. August Martinucci

COMMITTEE ON NURSING SC-13

Following discussion of the recent ISMS Board of Trustees action denying approval of proposed nursing legislation and financial support for a state survey of nursing needs and resources, the Committee adopted the following statement as its official position on these matters:

- I. We recognize the autonomy of the nursing profession in matters of nursing education, research, nursing services, standards of employment practice and compensation at realistic levels.
- II. We reaffirm our established policy to work closely in pursuit of what informed and leadership members of the nursing profession deem best for comprehensive nursing care.
- III. We regret that the mammoth task of public education has necessitated expenditure in combating misleading federal legislation proposals which strain our financial status to the point where worthwhile projects such as your nursing service survey cannot be favorably considered for financial aid. We do wholeheartedly support it in principle, however, and recognize the need for such a study.

IV. We await request for aid and guidance in the matter of prudent legislation in fields of common interest.

V. We invite combined study groups in matters of present concern and those that may evolve as a result of program, automation and other developments.

In order to keep abreast of nursing activities, the Committee requested the staff member assigned to it to prepare a schedule of forthcoming nursing organization meetings and advise the Chairman when medical representation is suggested. The Chairman will appoint a committee member to attend each meeting and make a brief report to the Chairman afterwards.

Dr. Scrivner suggested that spokesmen from nursing organizations be invited to attend meetings of the Committee on Nursing and the ISMS Board of Trustees from time to time in order to establish better liaison between medicine and nursing. Further, it was suggested that the Committee offer to participate regularly in nursing organization conventions.

The staff was directed to request the AMA to put members of the Committee on its mailing list to receive nursing publications and communications on a regular basis.

The Chairman will request the Illinois Department of Registration and Education to put him on its mailing list to receive department directives as another means of keeping the Committee informed of nursing activities.

Dr. Herbolsheimer suggested that:

The Committee request from the State Department of Health and/or Registration and Education or the Division of Nursing of the Public Health Services (Washington) the privilege of being informed from time to time on developments in Illinois of that part of the Health Professions Educational Assistance Act which pertains to nursing education. If the Committee were informed about (1) the agency or agencies handling the details of this legislation in Illinois, (2) the overall plan, and (3) the volume of and distribution of the new construction and renovation, the teaching grants, traineeships and loans, it might be possible for organized medicine to be more helpful to the institutions and individuals concerned in these efforts to improve nursing care.

W. I. Taylor, *Chairman*

Angelo P. Creticos	Henrietta Herbolsheimer
J. O. Firth	H. J. Kolb
Anna A. Marcus	
Ex-officio: Ted LeBoy	
W. C. Scrivner	

COMMITTEE ON NUTRITION SC-14

The annual Nutrition Conference, sponsored by

the Committee on Nutrition of the Illinois State Medical Society was held Oct. 9, 1964, at the Center for Continuing Education of The University of Chicago. Co-sponsors for this meeting were the Chicago Nutrition Association, Illinois Dietetic Association and the Illinois Nutrition Committee. The meeting was well attended. There were approximately 300 nutritionists, dieticians, doctors and other allied disciplines present.

Our program for 1965 will include a meeting Oct. 8, 1965, in Rockford, at which the Winnebago Medical Society will be host to the Committee on Nutrition and the Illinois Nutrition Committee. Final plans will be completed shortly for this meeting.

Paul A. Dailey, *Chairman*

James R. Wilson	W. I. Taylor
John B. Hall	Paul R. Cannon
Warner H. Newcomb	Fred C. Endres

JOINT COMMITTEE ON PERINATAL MORTALITY SC-15

The Committee's activities during the year fell into two areas: continuation of the pilot study of perinatal mortality in 11 counties, and the development of a program to establish a unified, standard maternal and perinatal study for the entire state.

The most current report of the Committee reveals that 406 forms have been received, of which 328 have been coded. These consisted of 125 still-born deaths and 203 liveborn.

Analysis of the forms has been enlightening and justifies putting the study on a statewide basis as the foundation for an educational program to reduce the incidence of these deaths.

During the year a number of meetings were held with Dr. Stuart Abel, Chairman of the Illinois Association for Maternal and Child Health and others interested in a program to standardize all maternal and perinatal statistics throughout Illinois. There is a need for a uniform procedure of reporting, classification and analysis, and utilization of results of such a study.

After much discussion, a master plan was submitted to the Board of Trustees of ISMS and was approved. The plan is complex, involving state, county and Chicago health departments, and calls for the cooperation of about 10 medical organizations. Efforts are now under way to obtain the endorsement of these groups prior to developing a budget for the program.

The Educational and Scientific Foundation of ISMS will be charged with raising funds for the project on a five-year schedule. The program will be under the auspices of ISMS with the other groups cooperating.

There is no central maternal and perinatal mortality registry in any state in the country and this could be a prototype for others to follow. The ultimate

goal is to reduce the incidence of these deaths in Illinois.

Herbert F. Philipsborn, Jr., *Chairman*

William W. Curtis	D. F. Rawlings
Paul A. Dailey	John H. Rendok
Robert R. Hartman	Simon Y. Saltman
Harry L. Lewis	Walter G. Steiner
Leo G. Perucua	John A. Taft, Jr.
Velma Foresman	

COMMITTEE ON RADIATION SC-16

After the introduction of the Radiation Monitoring Act under the Illinois Department of Public Health, there were a number of questions raised by the physicians affected by it. The Nuclear-Chicago Corp., manufacturer of monitoring devices, offered to provide speakers from its staff to explain the conditions of the act, subject to the approval of the Committee.

Meetings were held to work out the content of the presentation by Nuclear-Chicago personnel and the Committee approved the program. Nuclear-Chicago ran a full-page announcement of its service in the *Illinois Medical Journal* and a notice was sent to county medical secretaries describing the availability of speakers. Representatives of the Department of Public Health were present at all meetings and endorsed every step of the program.

The Committee would like to extend its appreciation to Nuclear-Chicago Corp. for its generosity in establishing the speakers bureau on the Monitoring Act. Its efforts to explain the act and the details of monitoring systems were a real service to those physicians covered by the act.

Howard C. Burkhead, *Chairman*

Abram H. Cannon	Robert W. Donnelly
Stephen L. Casper	C. W. Weidenheim
James A. Crilly	Harvey White
Fred H. Decker	Raymond B. White

Ex-Officio: J. Ernest Breed

Carl E. Clark

Consultant: Robert S. Laudauer

COMMITTEE ON TUBERCULOSIS SC-17

On motion by Otto L. Bettag, M.D., and a second by David F. Loewen, M.D., the Committee at its meeting on Jan. 19, 1965, recommended that a resolution be prepared endorsing adequate funds for the state laboratory expansion, new buildings, etc.

The resolution referred to above was adopted Feb. 16 as follows:

Whereas, the physical facilities in present state

laboratories are grossly inadequate for the examination of specimens for tubercle bacilli in the volume needed for the control of tuberculosis in this state, and

Whereas, specific identification of the organism causing tuberculosis is necessary before a definite diagnosis can be made, and

Whereas, other acid fast organisms, previously considered to be tubercle bacilli must be clearly differentiated in order to make an accurate diagnosis and refine treatment, and

Whereas, the causative organism often becomes resistant to the drugs most commonly given to combat the infection, necessitating supplementary laboratory tests to determine the suitability (or efficacy) of other drugs for treatment, and

Whereas, these determinations involve detailed laboratory study by competent microbiologists, and

Whereas, microbiologists who examine these specimens should be properly protected against the hazards of their work, and

Whereas, expansion of the physical facilities for the state laboratories, has already been requested by the Department of Public Health in its current biennial request,

THEREFORE BE IT RESOLVED that the Tuberculosis Committee of the Illinois State Medical Society does recommend that, the Board of Trustees of the Illinois State Medical Society take appropriate action to implement the request of the Illinois Department of Public Health and in so doing protect the citizens of the state from unnecessary exposure to this communicable disease, tuberculosis.

Some further discussion of hospital admission chest x-rays was indulged in. The Committee also reviewed the question of chest x-ray examination and tuberculin testing in nursing homes.

It was the feeling of the Committee that county medical societies be encouraged to establish tuberculosis committees. Such committees should outline the policies relative to tuberculosis control in their counties and work in cooperation with voluntary agencies and sanatorium boards. In this connection the objectives of the Surgeon General's task force on Tuberculosis Control and the Minimum Program Standards of the Illinois Tuberculosis Association should be re-emphasized and brought to the attention of all physicians.

Charles K. Petter, *Chairman*

Otto L. Bettag

Charles A. Lang

William J. Bryan

David F. Loewen

Clifton F. Hall

George C. Turner

George W. Holmes

Raymond R. Runde

Ex-Officio: William E. Adams

Edward A. Piszczek

Darrell H. Trumpe

COMMITTEE ON VITAL CERTIFICATES SC-18

The Committee was appointed to consult with the Department of Public Health at its request on matters pertaining to vital certificates. At this time, no request for a meeting has been made. In the event a meeting is called, a supplementary report will be offered. It would seem that the Committee is justified on a standby basis for future use.

H. Close Hesselstine, *Chairman*

Newton DuPuy

Jacob E. Reisch

EDITOR ILLINOIS MEDICAL JOURNAL SC-19

Three major innovations mark the progress of the Illinois Medical Journal over the past year. A special Reference Issue, published last August was the first of these. It was intended as an up-to-date compendium of ISMS organization, services and medical-legal information and will become an annual feature to keep members better informed.

The new cover and editorial format which made their debut with the first reference issue proved to be so attractive and well received that they were adapted for use in subsequent issues. John Kinney, our advertising manager, reported that better readership resulting from the improved appearance of the journal has been an important factor in the favorable response expressed by our advertisers.

To keep the Illinois physician abreast of the latest advances in the various medical specialties, the Illinois Medical Journal was especially pleased to initiate a continuing series entitled "Medical Progress," beginning in the November issue. A result of requests made in a recent IMJ readership survey, "Medical Progress" is written by a group of recognized authorities as reviews of latest developments in their particular specialty. Commendation is due Dr. Harvey Kravitz for his tireless efforts in formulating this section and functioning as its editor.

A special expression of gratitude and thanks is due to Dr. J. Ernest Breed, who functioned as coordinating editor of a special radiology symposium which appeared in the September, 1964 issue. The physicians who read this symposium agreed that it offered the non-specialist a concise, current review of the tremendous advances taking place in the field of radiology.

Although an assistant editor has not been found to replace Robert Zavrel, who resigned in 1964, William Anderson has been retained in that capacity on a part-time basis through June, 1965. Currently, the existing staff of Mr. Kinney, Mr. Anderson and Miss Maureen McCarthy, working under the administrative direction of Albert Boeck, have performed splendidly in maintaining and improving

the quality and appearance of the journal. Each of these persons deserves a well-sounded note of appreciation for their efforts during the past year.

In all, 127 medical articles were published in 1964. Of these, three were part of the continuing "Medical Progress" series; 76 were standard clinical papers; 11 were Dr. Leon Love's View Box presentations; one was Dr. Julius M. Kowalski's outdoor medicine feature; and one Reference Page was run. In addition, 35 editorials dealing with pertinent medical subjects were published.

During the first two months of 1965, 13 clinical papers, two View Box features, 8 editorials and two Medical Progress Papers were published.

In the March, 1965, issue we published a special, 24-page insert on the entire ELDERCARE program for Illinois physicians, including the concept and public education campaign sponsored by our Society.

This will serve as a complete and permanent reference on this vital issue for all physicians in the state.

Theodore R. Van Dellen, *Editor*

EDITORIAL BOARD SC-20

The Editorial Board of the Illinois State Medical Society held no meetings during the past fiscal year. At the previous meetings of the board there was much discussion, and suggestions for the improvement of the format of the journal, the utilization of the Editorial Board in a consultative capacity in reference to articles to be accepted for publication in the journal, and other matters. These reports were submitted to you in the past years and were published in the journal and handbook given to the members of the House of Delegates. In other words, the function of the Editorial Board Committee is status quo.

The present monthly issues of the *Illinois Medical Journal* are a decided improvement over the past years' issues. The articles are of a higher caliber, more scientific in scope, and the format including illustrations is good. In general, I believe we can say that the journal of the Illinois State Medical Society is one of the best journals published by state societies.

S. A. Levinson, *Chairman*

Frederick H. Falls	Francis L. Lederer
Edwin F. Hirsch	Charles Mrazek
James H. Hutton	Clarence J. Mueller
Julius M. Kowalski	Jacob E. Reisch
Harvey Kravitz	Arkell M. Vaughn
Edward F. Webb	

JOURNAL COMMITTEE SC-21

Publishing operations of the Illinois Medical

Journal, in the opinion of the Committee, were commendably conducted within the approved journal budget for 1964.

Overall income from the sales of advertising space, reprints and subscriptions increased by approximately \$10,000 over the previous year. Net income from publishing activities rose to \$89,534 in 1964 from \$79,875 in 1963. Net income from the sale of advertising space was \$84,106 last year—up from an earlier projection of \$77,000 at the beginning of the year.

To help compensate for an anticipated deficit in the Society's general budget for 1965, the Journal Committee and Board have approved a journal operating budget of \$101,300. This is a reduction in the original proposed budget from \$105,000 for the year. Operating economies have been and will continue to be explored in all directions relative to reducing the deficit.

Albert Boeck, with approval of the committee, has negotiated a new printing contract with Service Printers, Inc., in Chicago for publication of the journal, effective with the May, 1965, issue. It is anticipated that the new contract will save approximately \$4,000 a year in printing expenses. Because of printing trade practice, it was not possible to negotiate the contract earlier, or additional savings would have been realized.

The Committee wishes to emphasize this change in no way reflects upon the printing standards of Neely Printing Co., which has served us well during the past three and one-half years. Appropriate communications have been sent to the Neely Co. informing it of the severance date, with appreciation for the quality of the work done and excellent rapport in publishing the journal. This was a matter of a budget reduction in line with other operating economies of the Society generally.

Although members of the Committee were pleased to note the increase in advertising revenue during the past year, we are cautious in anticipating levels of income for the journal comparable to the late '50s. The projection for 1965 is \$80,000 net, which we hope may be revised upward as the year progresses.

Government regulations on the testing and marketing of new pharmaceuticals have severely affected journal advertising, especially the state medical journals. Relatively, we have done well in maintaining our editorial product and position as one of the leading state society journals despite a reduction in revenue.

In regard to the new product situation, which is the substance of more advertising in the journal, between 1955-1959 the pharmaceutical industry introduced 231 new drug entities; between 1960-1964, it produced 146. The year ended with the smallest number in the 10-year span—only 15. During 1963 there were 18 new products introduced.

Other Matters

A proposal by the Board of Trustees to explore

consolidation of the Illinois Medical Journal with journals of adjoining state societies was instrumented by Mr. Boeck. Letters were forwarded to the appropriate administrative officers of Michigan, Wisconsin and Indiana Societies asking their reaction to the plan, and a meeting to explore the feasibility of a Midwest or Great Lakes Journal was held. Later follow-ups to this proposal by correspondence was not generally favorable and no further effort has been made to pursue the concept at the present time.

Cigarette advertising in the journal was discontinued, effective with the January, 1965, issue, upon action of the Board. This also applies to the sale of exhibit space to tobacco manufacturers at the annual convention.

An innovation for 1964 was the IMJ Reference Issue which was published in August and is expected to be continued as a regular August issue with improvements each year. The issue was well received by the membership; however, too many members did not realize the importance of saving it for reference throughout the year.

An adequate staffing pattern of the journal is being studied by this committee with the intent to provide a highly competent and professional staff to maintain standards of excellence in the publication of the journal. Recommendation have been and will continue to be made to the Board of Trustees in this regard.

A policy decision was made by this committee and confirmed by the Board of Trustees on the acceptance of inserts that deviated in format from the standard type of advertising insert. The decision caused a cancellation of an advertising contract in the latter months of 1964 and the first quarter of 1965, which was regrettable, but in the Board's opinion, a necessary decision.

Effective with the May issue, the PULSE section published by the Public Relations Division will no longer appear in the journal. It will appear as a new eight-page newsletter to be circulated to the membership with additional circulation in the medical and paramedical fields to an anticipated 18,000 persons. Roche Laboratories Division of Hoffmann-LaRoche, Nutley, N.J., will contribute \$22,000 to its production with two advertising pages planned for each issue. The contents of the PULSE will be principally related to public relations activities of the Society, but other activities of the Society are expected to be included.

A former advertising director and manager of the Publications Division of New York State Medical Society was instrumental in obtaining the grant from Roche Laboratories for production of the PULSE in its new format. He has now been retained as a special representative of the Illinois State Medical Society for advertising space sales on the journal and exhibit sales for the convention. He will function on a percentage commission basis without salary.

Journal Staff Activities

Staff members have been active in publishing organizations and activities in addition to their regular duties. The ISMS can be proud of the capabilities of its journal staff.

Mr. Boeck and John Kinney attended a number of meetings of national and regional organizations, such as the Association of Medical and Allied Publications in New York, the regional meeting of the State Medical Journal Advertising Bureau in Baltimore, meetings of the Pharmaceutical Advertising Club of New York, the Midwest Pharmaceutical Advertising Club of Chicago and the Pharmaceutical Manufacturers Association in Chicago.

Mr. Boeck was a speaker on the seminar program of the Association of Medical and Allied Publications held in New York last November and has since been elected to the Board of Governors of that association.

Mr. Kinney is now serving as chairman of the Publicity and Public Relations Committee of the Midwest Pharmaceutical Advertising Club.

Our meetings with the staff during the year have been productive in planning and producing a better Illinois Medical Journal. The committee highly compliments the willingness of the staff to meet at odd hours and on week-ends, and further wishes to acknowledge their progressive ideas and suggestions for the journal.

Jacob E. Reisch, *Chairman*

J. Ernest Breed

Frank J. Jirka

Newton DuPuy

Darrell H. Trumpe

EDUCATIONAL & SCIENTIFIC FOUNDATION SC-22

The Educational & Scientific Foundation received word during the year that its film, "Modern Management of Multiple Births," had been given the seal of approval of the American College of Obstetrics and Gynecology and that the film would be shown at the College's 1965 annual meeting. Arrangements were made to strip the approval seal into the film.

The Foundation has been working closely with the Combined Committee to Study Maternal and Perinatal Mortality in anticipation of the committee's request for aid in financing a statewide survey of maternal and perinatal deaths. Illinois will be the first state to conduct an all-inclusive study of this type and the success of the project depends upon the cooperation of a wide range of medical and hospital organizations.

In cooperation with the Committee on Continuing Education, the Foundation has been studying the feasibility of distributing recorded diagnostic problems to ISMS members on a subscription basis. The educational series would be produced by Decision Discs, presented on phonograph records by individual members of ISMS with material approved by the Continuing Education Committee,

and mailed to subscribers. The Foundation is considering financing a market or trial test of the project.

One of the Foundation's first projects, support of the Impartial Medical Testimony program, will come to an end during the coming year. After launching the program with funds from the ISMS Foundation and from other philanthropic organizations, sponsors of the project have recommended that the program be supported by the courts in Illinois and appropriate requests for budget have been made to the state.

Gifts received during the year have included several bound volumes of historical medical literature from Peter R. LaPato of Chicago, and these have been deposited with the John Crerar Library, a technical library located on the campus of the Illinois Institute of Technology. Gifts in kind are welcomed by the Foundation and ISMS members are reminded that there are tax advantages for donors of securities and other property that have appreciated in value since they were acquired.

Finally, the Foundation is grateful to the McHenry County Medical Society for its gift of \$500 which will be assigned to a Foundation project in the near future.

Harlan English, *Chairman*

William E. Adams

Edward A. Piszczek

B. E. Montgomery

Jacob E. Reisch

REPRESENTATIVE TO THE ILLINOIS JOINT COMMISSION ON SCHOOL HEALTH SC-23

The Illinois Joint Commission on School Health has been organized some 10 years. There was a long lag in the first few years of its organization as to what they were to accomplish. The Joint Commission then directed its efforts primarily to the publication of guidelines for use in school systems and a lot of the controversy revolved around how it was to be made up and the ideas varied from three categories to 11 various categories and as to whether it should be made up of loose-leaf type of folder or whether they should be put up in booklet-pamphlet form. The ultimate decision was that there would be three different publications. One publication would be the Guidelines for School Health Programs; one on School Health Environment and one on Programming for Health Instructions. The Guidelines for School Health Programs was published in July, 1961 and it was met with a great amount of welcome and enthusiasm. The publication on School Health Environment was a re-edition of one that existed prior. However, the publication of the Programming for Health Instruction is still in the composing and editorial phase. They have run into a great deal of difficulty on this thing and it is still under advisement and editing. The Guidelines for School Health Pro-

grams has been revised within the past year. Some errors in nursing were corrected and some diction errors were corrected as well as some spelling corrected. However, this only applied to a few pages of the original book so fly-leaves have been made to be inserted in the original Guidelines and these are available. There were not many new full books published. I think only about 1,500 were published, but there are plenty of fly-leaves available to insert in the original Guidelines.

Conference on Physicians and Schools

The Joint Commission meets twice a year. However, one meeting is primarily the executive committee meeting. The spring meeting, which is always the annual meeting, is a full Joint Commission meeting. There will be such a meeting this spring before our State Medical Society meets.

One other activity that we have gone into has been the promotion of the Third Illinois Conference on Physicians and Schools which was held on Dec. 3, 1964. It was limited by necessity of arrangements by invitation to people from many of the various agencies involved. It was supported financially jointly by the Illinois State Medical Society, the Illinois Dental Society, the Illinois Education Association, the Illinois State Department of Health, and the Illinois Department of Public Instruction. This was a tremendous success. I served as Chairman on the discussion panel. The program brought forth many favorable comments and I think medicine was well favored as a result and some myths and doubts probably cleared by this discussion panel. The noon luncheon session was addressed by Dr. Delbert Oberteuffer who is a national authority on school health.

Your representative also participated in a panel at the University of Illinois before the Illinois High School Basketball Coaches meeting on Nov. 8, 1964. We anticipate another such session on Apr. 9 before the Illinois High School Football Coaches meeting.

Physical Fitness Conference

I also attended a Conference on Physical Fitness of the President's Council at the University of Illinois on Oct. 16 and 17, 1964. This was an experience in itself. I do not know how much value it is to medicine, but if I were given the opportunity to go as a representative of the Society to such a meeting again, I would be glad to do so. It was amazing how well certain things can be worked into; although, you may not have much time for physical fitness in your daily life, but it can be worked out if you have the motivation to do so.

Proposed programs will be the two meetings per year of the Joint Committee. One meeting would be for executive meeting; the other meeting for the whole Commission. In 1966 we hope to put on another Illinois Statewide Conference on Physicians and Schools as the general scheme of things is to have this one the year between the national con-

ference of Physicians and Schools. I have already mentioned the proposed meeting with the football coaches and this will have taken place by the time of the meeting of the House of Delegates. We are also in the discussion stage of promoting a state-wide athletic injuries clinic somewhere in the state making use of M.D.s who have team connection experience, dealing with more specific injuries occurring in athletics and also making use of reputable trainers and use of men recognized for rehabilitation of athletes and physical education experts.

I wish at this time to acknowledge Thomas Janeway who is Health Advisor to the Illinois Department of Public Instruction, Dr. Donaldson Rawlings from the Illinois Department of Public

Health. Jim Lewis who is Chairman of the Illinois Joint Commission on School Health and many others for their participation in the Third Illinois Conference on Physicians and Schools.

I also wish to thank the Chairman of the Board of Trustees and the Board of Trustees of the Illinois State Medical Society as a whole for giving me the opportunity to serve in the various capacities concerned with school health, athletic injuries and as a representative to the President's Council on Physical Fitness.

Willard W. Fullerton,
*Representative of the Illinois State Medical
Society to the Illinois Joint Commission
on School Health*

RESOLUTIONS

Resolution #65M-1

Introduced by: Montgomery County Medical Society

Subject: *Drug Formulary—Illinois Department of Public Aid*

Referred to: Reference Committee on Economics, and Insurance, Clifton L. Reeder, *Chairman*

WHEREAS, The Department of Public Aid of the State of Illinois has seen fit to issue a list of drugs that may be used for patients receiving aid from this department, and

WHEREAS, This drug list is restrictive in that it invades the right of the physician in whom these patients have entrusted lives and health from prescribing those drugs that in his judgment are the best for his patient, and

WHEREAS, The restrictions imposed in the selection of the drugs for this group denies them the best medical care which all physicians desire to give, Therefore, be it

RESOLVED, That the MONTGOMERY COUNTY MEDICAL SOCIETY urges its representative, the Illinois State Medical Society, and its member county societies to do everything in their power to help reverse this action of the Department of Public Aid in order that all citizens of the State of Illinois may have the right to the best drugs available.

Unanimously adopted by the
MONTGOMERY COUNTY MEDICAL
SOCIETY in session Oct. 28, 1964.

Resolution #65M-2

Introduced by: St. Clair County Medical Society
Subject: *Drug Formulary—Illinois Department on Public Aid*

Referred to: Reference Committee on Economics, and Insurance, Clifton L. Reeder, *Chairman*

WHEREAS, The members of the St. Clair County Medical Society are interested in good medical care of all people; and

WHEREAS, The members of the St. Clair County Medical Society feel that recipients of I.D.P.A. assistance deserve the same quality of medical care including medications; and

WHEREAS, The present Drug Manual as printed does not allow sufficient latitude to select medications as one would for other private patients; and

WHEREAS, There is sufficient evidence that even the cost of medication can be increased in certain instances; and

WHEREAS, The usage of the present drug manual by participating physicians is a cumbersome and time consuming procedure which detracts from the primary medical purpose of expeditious diagnosis and treatment of patients, now therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society withdraw its approval of the present Drug Manual.

Unanimously adopted by the
ST. CLAIR COUNTY MEDICAL SOCIETY
in session Jan. 7, 1965.

Resolution #65M-3

Introduced by: Christian County Medical Society
Subject: *Drug Manual—Illinois Department of Public Aid*

Referred to: Reference Committee on Economics, and Insurance, Clifton L. Reeder, *Chairman*

WHEREAS, The Illinois Department of Public Aid has seen fit to issue a list of drugs that may be prescribed for patients receiving aid from this organization; and

WHEREAS, This list is restrictive in that it invades the realm of the physician, in whose hands the welfare of the patient lies, and whose judgment

should be supreme in selecting medicines for his patients; and

WHEREAS, The general practitioners are dedicated to the care of the whole patient, we find ourselves unduly restricted by an arbitrary list of drugs prepared by a third party; and

WHEREAS, The restrictions imposed in the selection of the drugs allowed for this group of patients is undemocratic, now therefore be it

RESOLVED, That the Christian County Medical Society goes on record condemning this restriction of the physicians' rights; and, be it further

RESOLVED, That this organization goes on record to refuse to follow the dictates of a bureaucratic body, in an effort to insure its failure, and be it

RESOLVED, That the Christian County Medical Society goes on record as opposing any prepared formulary and desires to return to the practice of free medicine, and be it further

RESOLVED, That this resolution be forwarded to the Illinois State Medical Society Advisory Committee to the Illinois State Department of Public Aid, to the trustee of the 7th District of Illinois State Medical Society and to the Secretary of the Illinois State Medical Society, and be it further

RESOLVED, That the Christian County Medical Society cooperate with other interested organizations in correcting this infringement on the rights of the physician to prescribe the drugs of his choice.

Resolution #65M-4

Introduced by: Winnebago County Medical Society
Subject: *Drug Manual—Illinois Department of Public Aid*

Referred to: Reference Committee on Economics, and Insurance, Clifton L. Reeder, *Chairman*

WHEREAS, The Illinois Department of Public Aid Drug Manual establishes interference with the normal doctor-patient relationship by providing third party intervention; and

WHEREAS, In some instances, the drugs listed have been selected *arbitrarily* and with discrimination to some better known, more widely used drugs, and to the benefit of some lesser used, second rate drugs, and

WHEREAS, In effect, we have one group dictating to individual practicing physicians those drugs he may or may not use, thereby affecting the welfare of the patient; and

WHEREAS, It appears that the Illinois Department of Public Aid Manual was established for the convenience in handling administrative problems of that organization rather than for the consideration and treatment of the individual patient, now therefore be it

RESOLVED, That the Winnebago County Medical Society express support of the recent resolution of the Illinois Academy of General Practice in opposition to this drug manual, and be it further

RESOLVED, That the Winnebago County Medical Society work with other interested organizations toward the repeal of this manual and the restoration of individual initiative based upon each physician's knowledge.

Approved by general membership, Dec. 4, 1964.

Resolution #65M-5

Introduced by: Kendall County Medical Society
Subject: *The Liberty Amendment to the U.S. Constitution pending in Congress*

Referred to: Reference Committee on Legislation and Public Affairs, L. F. Mammoser, *Chairman*

WHEREAS, America's greatness is the product of rigid Constitutional law that provides freedom from arbitrary governmental interference, and

WHEREAS, Violations of this principle have produced hundreds of federal corporate activities now competing with the private enterprises of the American people, and

WHEREAS, These federal corporate activities have taken over 40% of the land area and 20% of the industrial capacity of the nation, and require more than half the federal revenue to pay their losses and hidden costs, and

WHEREAS, The purpose of the Ninth and Tenth Amendments to the Constitution was to limit the government to the specific activities delegated to it by the Constitution, and

WHEREAS, The Fifth Article of the Constitution provides that the people can exercise their rights to a redress of grievances through an amendment requiring concurrence of $\frac{2}{3}$ of the members of both Houses of Congress, or by the application of the Legislatures of $\frac{2}{3}$ of the several states and in either case, ratification by $\frac{3}{4}$ of the States;

THEREFORE, BE IT RESOLVED, that we, the members of the Kendall County Medical Society in session assembled this 3rd day of December, 1964, exercise our constitutional power to petition the Congress of the United States and the Legislature of the State of Illinois to preserve and fortify the intent and purposes of the Constitution by submitting to the people for ratification the LIBERTY AMENDMENT to the Constitution, now pending in Congress at H.J. Res. 23, and already approved by Wyoming, Texas, Nevada, Louisiana, Georgia, South Carolina and Mississippi, which provides that:

"Sec. 1. The Government of the United States shall not engage in any business, professional, commercial, financial or industrial enterprise except as specified in the Constitution.

"Sec. 2. The constitution or laws of any State, or the laws of the United States shall not be subject to the terms of any foreign or domestic agreement which would abrogate this amendment.

"Sec. 3. The activities of the United States Government which violate the intent and purposes of this amendment shall, within a period of three years from the date of the ratification of this amendment, be liquidated and the properties and facilities affected shall be sold.

"Sec. 4. Three years after the ratification of this amendment the sixteenth article of amendments to the Constitution of the United States shall stand repealed and thereafter Congress shall not levy taxes on personal incomes, estates, and/or gifts."

BE IT FURTHER RESOLVED, That a copy of this Resolution be included in the minutes of this meeting, and that certified copies of it be sent to (1) the members of both Houses of Congress from this State, (2) the members of the Legislature of this State, (3) to newspapers and other media that others may know of this action and may emulate it, and (4) to the Liberty Amendment Committee of the U.S.A., 6413 Franklin Avenue, Los Angeles 28, California.

Resolution #65M-6

Introduced by: DuPage County Medical Society
Subject: *Shortage of general practitioners.
Poor distribution of the Practicing
Physicians.*

Referred to: Reference Committee on Publications and Scientific Services, C. H. Walton, *Chairman*

WHEREAS, It is now apparent that one of the major problems in the practice of medicine today is the poor distribution of practicing physicians creating a severe doctor shortage in the rural and rapidly growing suburban areas; and

WHEREAS, There is a very rapid and significant trend away from the general practice of medicine; and

WHEREAS, It is becoming obvious that a large proportion of the population desires and is increasingly demanding a reinstitution of either more general practitioners or creation of family physicians in the form of internists and pediatricians; therefore.

BE IT RESOLVED, That the Illinois State Medical Society appoint an Ad Hoc committee composed of primarily practicing physicians representing different areas of the state as well as including both general practitioners and specialists to immediately study in consultation with the representatives appointed by the medical schools the problem herein outlined and make recommendations to the Board of Trustees of the Illinois State Medical Society as to possible methods of solving this problem.

Resolution #65M-7

Introduced by: DuPage County Medical Society

Subject: *Rotating Internships as an Illinois program*

Referred to: Reference Committee on Publications and Scientific Services, C. H. Walton, *Chairman*

WHEREAS, The actual fact of the presence of a doctor shortage in many areas has been established; and

WHEREAS, The need for more family physicians is apparent to both the public and the practicing physicians; and

WHEREAS, It is apparent that the medical schools strongly oppose the re-establishment of a mandatory rotating type internship as a prerequisite for licensure in the State of Illinois; and

WHEREAS, Several large university affiliated hospitals have in the recent past created the policy of straight internships and eliminated offering rotating internships which policy greatly inhibits the development of more general practitioners or family practitioners; therefore,

BE IT RESOLVED, That the Illinois State Medical Society through its Board of Trustees should urgently request the five medical schools in the State of Illinois to reinstitute the practice of offering rotating internships in addition to straight internships and the Illinois State Medical Society should encourage all interested hospitals of over 150 beds in size, particularly those hospitals located in areas of doctor shortage, to so organize themselves and propose a program offering rotating internships so that more positions are available for graduating medical students to enter the rotating internship program and thus make themselves well qualified for the family practice of medicine.

Resolution #65M-8

Introduced by: DuPage County Medical Society
Subject: *Medical Education for physicians
in practice and Physicians in re-
search*

Referred to: Reference Committee on Publications and Scientific Services, C. H. Walton, *Chairman*

WHEREAS, The fact of a doctor shortage is now recognized by the public and the practicing physicians; and

WHEREAS, The medical schools in the past 10 years have become more and more research oriented, both as to their increased percentage of full-time employed faculty and to the type of curriculum offered the students; and

WHEREAS, The financing of these ever increasing research projects has become more and more dependent upon Government grants, which in turn are dependent upon research projects for their approval; and

WHEREAS, Many of the research oriented faculty have little interest in teaching physicians the art of the practice of medicine but rather are far

more interested in the improvement in their research facilities and projects for the advancement of scientific knowledge on a particular subject; therefore,

BE IT RESOLVED, That the Illinois Medical Society through its Board of Trustees should encourage the curriculum planners and the Deans of the medical schools to seriously consider the establishment of a parallel program of two types of medical education, both considered equal in importance but one directed toward the development of practicing physicians and one directed toward the development of research oriented physicians.

BE IT FURTHER RESOLVED, That, within the framework of the practicing physician section, enlargement of the faculty should be encouraged to include more part-time practicing physicians to instruct the students in the art and practice of medicine and development of better overall patient care.

Resolution #65M-9

Introduced by: DuPage County Medical Society
Subject: *Preceptor visits by medical students for short training periods*
Referred to: Reference Committee on Publication and Scientific Services. C. H. Walton, *Chairman*

WHEREAS, The Doctor shortage in the rural and suburban communities is increasing each year; and

WHEREAS, Many of the junior and senior students in the medical schools have very little knowledge and understanding of the actual problems involved in the daily practice of medicine; and

WHEREAS, Many and perhaps the majority of the medical school faculty have either never practiced medicine or have given up the practice of medicine for full-time teaching many years ago and therefore are not recently experienced or specifically interested in the teaching of the practical aspects of the practice of medicine; therefore,

BE IT RESOLVED, That the Illinois State Medical Society through its Board of Trustees encourage the medical school curriculum planners to incorporate in their curriculum or encourage and help the students obtain practical knowledge of the practice of medicine from well-qualified physicians in the various communities of doctor shortage by granting permission either as a part of a curriculum or by working out mechanisms for visiting and actually living with these doctors for periods of 3-7 days sometime during their medical curriculum or between quarters of the medical school year.

It is also believed desirable to have the students who wish to practice medicine obtain their internship in a community hospital and if they desire to specialize to then return to the University center for their residencies and be accepted by the medical faculty without prejudice with regard to their site of internship.

Resolution #65M-10

Introduced by: Champaign County Medical Society
Subject: *Upgrading of obstetrical fees in IDPA cases.*
Referred to: Reference Committee on Economics and Insurance, Clifton L. Reeder, *Chairman*

RESOLVED that consideration be given to an immediate up-grading of obstetrical fees in Illinois Department of Public Aid cases, to an amount more compatible with the minimal county fee schedule.

RESOLVED That there be a separate allowance for neo-natal care of the newborn in an amount more compatible with the minimal county fee schedule.

Resolution #65M-11

Introduced by: Champaign County Medical Society
Subject: *Physician's Right to Prescribe Drugs of his Choice.*
Referred to: Reference Committee on Economics and Insurance, Clifton L. Reeder, *Chairman*

WHEREAS the Illinois Department of Public Aid has seen fit to issue a list of drugs that may be prescribed or dispensed for patients receiving aid from this organization, and

WHEREAS this list is restrictive in that it invades the realm of the physician in whose hands the welfare of the patient lies, and whose judgment should be supreme in selecting medicines for his patients, and

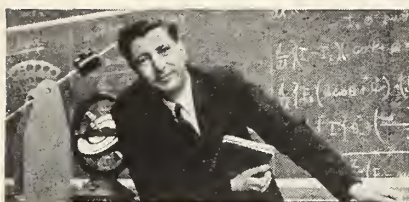
WHEREAS The restrictions imposed in the selection of the drugs allowed for this group of patients is undemocratic and dictatorial, Therefore, now be it

RESOLVED, that the Champaign County Medical Society go on record condemning this restriction of the physician's rights; and be it further

RESOLVED that this resolution be forwarded to the Illinois State Medical Society and the Illinois Department of Public Aid.

Stelazine[®] brand of trifluoperazine
**will calm your anxious working patient—
with little or no drowsiness**

When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll¹ used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration,

they were able to continue with and, in some cases, return to their daily work."

Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

Principal side effects, usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information. Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, *M. Press* 243:578 (June 29) 1960.



Smith Kline & French Laboratories, Philadelphia



THE PROSPECT OF IMMORTALITY. Robert C. W. Ettinger.
New York, Doubleday & Company, Inc., 1964,
pp. 190. \$395.

The author proposes a change in our method of disposing of the dead in order to insure immortality. He suggests freezing and storage at a low temperature. Glycerol will be used to protect the frozen cells.

Mr. Ettinger admits that the best technique of suspended death has not been developed, but is bound to come with research. He believes that most of us now living have a chance for personal, physical immortality. If civilization endures, medical science should eventually be able to repair almost any part of the human body, including damage from freezing and senile debility or other causes of death. This obviously cannot be done on the deceased who are cremated or are buried in the usual way.

Mr. Ettinger's book is stimulating and provocative.

T. R. Van Dellen, M.D.

HERNIA, edited by Lloyd M. Nyhus and Henry N. Harkins, with 105 contributors, 836 pages. J. B. Lippincott Company, Philadelphia.

Since it is 24 years after first publication of Iason's compendium on hernia, it is apparently appropriate for a modern encyclopedic volume on this subject to carry the identical title. Henry Harkins, the co-editor of this new time, was known in his University of Chicago days as a scholar-surgeon. This book on hernia distinctly carries his stamp and bears out his reputation.

One can reasonably question the need for another hernia book. But this one needs no justification. It is modern, complete, and interesting. It supplies a review of past knowledge, rakes out familiar problems, uncovers old chestnuts of dogma, but presents them in present-day terms. This is done by a forum format. Authorities such as Mark Ravitch, Donald Kozoll, and Philip Allison are allowed to hold forth *ex cathedra*. Their views are given the sanction of unlimited space. Thereafter, other, equally informed, surgeons comment succinctly upon the longer presentations. Their

views are the real meat of this publication. They give it character, reflect the personal experience of accurate observers, and allow the presentation of educated prejudice. In this respect the present text fulfills the aims of Sir Heneage Ogilvie, who desired of his own slim volume on hernia that it present "the personal and dogmatic rather than the transcriptive and obsequious."

Each surgeon today performing hernia repair is a self-styled authority on the subject. This is with some justification; nevertheless, it is the operating surgeon who will profit most from this volume. For example, the review of anatomy by Harkins' disciple, Robert Condon, is thorough and informative. It reflects painstaking observation and therefore its undue emphasis on the iliopubic tract is easily dismissed. Clatworthy's comments on pediatric herniae, Zimmerman's personal preferences, McVay's discussion of femoral hernia and Amos Koontz's comments upon this are in themselves worth the price of purchase. They are but the beginning. The remainder is a summation of today's best total hernia knowledge. The book is well edited, superbly illustrated, clearly printed, and altogether a splendid effort.

John J. Bergan, M.D.

PHYSICAL EXAMINATION OF THE SURGICAL PATIENT, J. Englebert Dunphy and Thomas W. Botsford, 396 pages, 215 illustrations. W. B. Saunders Company, Third Edition, Philadelphia, 1964.

Brevity, clarity, easy readability characterize the new edition of this popular surgical physical diagnosis text. It is a model of excellence, as were the two previous editions. However, one cannot help but be disappointed that previous errors are again perpetuated, that former omissions remain unfulfilled.

The superior sections remain. The chapter on examination of the abdomen is unsurpassed, that concerning the anus and rectum a model of completeness, and the new chapter by Starr on examination of the surgical cardiac most welcome. But nowhere is there a description of abnormal carotid and vertebral vas-

(Continued on page 498)



She lost weight

*** a result of**
'METHEDRINE'® brand
METHAMPHETAMINE
HYDROCHLORIDE
therapy

Her once unruly appetite is now well tamed with 'Methedrine' (methamphetamine hydrochloride)...an easy way to help control food craving and "hunger pains."

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

'Methedrine' brand Methamphetamine Hydrochloride: Tablets—5 mg., scored, in bottles of 100 and 1000.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

cular findings and their importance in prevention of stroke. There is no listing of surgically remedial causes of hypertension. There are the former digressions into descriptions of various diseases rather than development of the physical findings of such pathologic processes.

Despite its faults, there is no better volume than this one concerned with surgical physical diagnosis. Students will like its emphatic diagrams, surgeons will appreciate its concise manner.

John J. Bergan, M.D.

CORNEAL CONTACT LENSES. Edited by Louis J. Girard, M.D. Published by C. V. Mosby Company, St. Louis, 1964. Clothbound, 329 pages, 342 photographs and diagrams, 56 in color on six plates, references, index. \$19.75.

This timely book has filled a need for a definitive text on the subject of contact lens fitting from a medical standpoint. Prior to the publication of this text, physicians interested in fitting corneal lenses had to glean most of their information from books written by non-medical personnel or from technical and biased material supplied by the various lens manufacturers. The increasing number of patients desiring contact lenses has made a book of this type a necessity for the library of any physician interested in this phase of vision correction.

The text is the result of the combined efforts of the members of the Contact Lens Section, Baylor University College of Medicine and is skillfully edited by Dr. Girard. The book is divided into seventeen chapters covering standard nomenclature, historic evolution, metabolic and optical fundamentals, techniques of examination, fitting and dispensing of lenses, and technical data on the manufacture and modification of lenses. The authors describe in detail a most in-

teresting technique of fitting a custom designed lens by the method of topographical kerotometry. It is a definite step forward in the process of establishing more scientific lens fitting.

There is also a chapter devoted to the responsibilities of the ophthalmologist who does not do his own fitting but refers his patients to a contact lens technician. Though this procedure may work well in certain areas, the ultimate goal is for all the phases of contact lens fitting to be under the direct supervision and control of the ophthalmologist.

The book in general is well written and is the finest medical text on corneal lenses currently available.

Leonard A. Samat, M.D.

PEDIATRIC THERAPY, Harry C. Shirkey, M.D. 1104 pages

This volume that requires considerable reading to get to the meat of the many subjects under discussion. There are over seventy outstanding contributors who deal with special fields in more concise form. For example, the chapter on Hereditary Metabolic Diseases covers a very large and important field in pediatrics sufficiently for the purpose of the book and gives adequate bibliography for more detailed study.

Other chapters read more like a full textbook on pediatrics. Although the discussion on handling and treating children is in general practical and informative, it is material found in most standard textbooks.

It is of interest that the only treatment mentioned for synechia vulvae is instrumental separation of the labia. This can usually be accomplished with no trauma by applying dienesterol cream locally for ten days.

This book contains much information and numerous photographs. Unfortunately, the pictures in many instances, due to lack of color, fail to convey the proper impression.

Theodore Van Dellen, M.D.

CAMP MEMORIAL LECTURE

MAY 19

2:00 P.M.

SHERMAN HOUSE BALLROOM

EDWARD ROSENHEIM, JR.

PROFESSOR OF ENGLISH, UNIVERSITY OF CHICAGO

DISCUSSES

“THE SATIRISTS’ WAR ON MEDICINE”

Depend on low-cost,
low-dosage Prolixin
— once-a-day



Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

THE
SQUIBB
TRANQUILIZER

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

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SQUIBB DIVISION **Olin**

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



Approximately 22 Illinois Medical Assistants will take certification examinations June 25 and 26 at Northern Illinois University.

Between 200 and 300 women will sit for the 1965 certification examinations given at test centers throughout the United States. This is clear cut evidence that women are interested in becoming certified.

Since the examinations have been initiated—two years ago— a total of 61 assistants have become certified. Thirty one qualified in the clinical category, twenty six in the administra-

tive category, and four attained dual certification, demonstrating proficiency in both categories. This examination is not an attempt to evaluate a medical assistant's performance on her job. Rather it is intended to provide the medical assistant with an idea of her professional growth; to point out areas where improvement is needed; and to establish a goal for her to attain.

To enhance the growth of the certification program, Doctor, your assistance is needed. How can you help? First, urge your assistant NOW to consider taking this examination in 1966. She does not need to belong to a Medical Assistant Association to take this examination. Second, you might volunteer one night a week to teach the basics of anatomy, physiology, medical terminology, office procedure, etc. If you are interested in volunteering your services, contact your county medical assistant organization or your county medical society who will assist in organizing groups to participate in this educational program.

Wouldn't you be proud if your medical assistant became a Certified Medical Assistant? How much more proud would you be if a whole class of your students took the examination and passed.

Just the incentive of your encouragement and support would be a tremendous help.

For study outlines, information and application, write to: Mrs. Ethel Haase, 16315 Kenwood Drive, South Holland, Illinois 60473.

**HOW YOU CAN
HELP, DOCTOR**



RABIES WHERE YOU FIND IT

Proving that the disease, rabies, is where you find it, a recent occurrence in Douglas County points up the necessity for suspecting each and every animal bite inflicted on a human.

A young man was bitten by a mouse during the night. Being alert to the danger of animal bites, a trap was set and a mouse captured in the bedroom on the following night was submitted to the Department of Agriculture laboratory at the University of Illinois. Laboratory tests proved the mouse had rabies. The young man was started on anti-rabies treatment at once as a preventive measure.

Rabid rodents are such a rarity that more intensive tests were conducted by this laboratory as well as the laboratory of the Illinois Public Health Department. The results of the further tests were received recently by the Health Department and rabies was definitely confirmed in the mouse. Suspicion and prompt action by persons involved may have averted a tragic aftermath to "mouse bites man."

Because they frequently bite, even when unprovoked, large numbers of rodents are examined for rabies by laboratories each year, but few are found infected. For the 10-year period from 1954 through 1963, only 199 of the 47,211 laboratory-confirmed cases of animal rabies reported in the United States were rodents. Authorities believe that modern laboratory methods of confirming rabies in rodents would have eliminated some of the cases reported as positive in past years.

Dr. Franklin D. Yoder, state public health director, and Robert M. Schneider, director of the Illinois Department of Agriculture, again stressed the importance of several vital rules in rabies control and protection of life. First, suspect each animal bite and capture biting animal, dead or alive, for investigation. Second, wash wound thoroughly with soap and water and immediately consult a physician. Third, vaccinate all pets against rabies and do not allow a pet to join a dog pack. A pack is governed by mob rule and an owner is responsible for his dog.

Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in some hospitalized patients on higher than recommended dosage. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intra-arterial injection or periaxillary extravasation, both of which should be avoided. **More detailed professional information available on request.**

References: 1) Haywood-Butt, J. T.: *Rocky Mountain M. J.* 61:39 (Dec.) 1964. 2) Grady, R. W., and Rich, A. L.: *South. M. J.* 54:766 (July) 1961. 3) Steinberg, M., and Halz, W. G.: *New York J. Med.* 60:691 (March) 1960. 4) Javon, F.: *Santé publique* 13:161 (July 5) 1958. 5) Bizzori, D., et al.: *New York J. Med.* 63:529 (Feb. 15) 1963.



INTERNATIONAL PHARMACEUTICAL NEWS

The following condensations, taken from sources as indicated, give a thumbnail review of what is happening internationally in the field of pharmaceuticals:

THE PHILIPPINES HERALD, January 22, 1965—A new Health Department policy calls for importing drugs only if they cannot be manufactured locally or if the local stock cannot meet public demand. Health Secretary Manuel Cuenco said the scheme would spur Philippine drug manufacturers to produce drugs with the same quality as those manufactured abroad. A considerable number of U. S. and other foreign drug companies have manufacturing facilities in the Philippines.

* * *

ASSOCIATION OF BRITISH PHARMACEUTICAL INDUSTRY ACTION, London, January 22, 1965—"If the British patent system encourages the wrong sort of innovation, or does not encourage at all, it is the British companies who will suffer most both in Britain and abroad," said Dr. Gordon Fryers, Managing Director of Nicholas Laboratories, Ltd.

Dr. Fryers noted that the falling proportion of worldwide pharmaceutical research being carried out in Britain could encourage companies to use "secret processes" to protect their individual know-how.

* * *

DIARIO DE SAO PAULO, Sao Paulo, Brazil,

December 9, 1964—Raimundo de Brito, Minister of Public Health, said he opposes nationalized medicine. A doctor himself, de Brito said that doctors should not be ordered around by people who are totally ignorant in the field of medicine. Only a minority of individuals support nationalized medicine and they do so for their own selfish interests, he said.

* * *

ECONOMIC TIMES, Bombay, India, December 11, 1964 — A comprehensive bill to amend the Indian Patents and Designs Act of 1911 is scheduled to be introduced in Parliament and would weaken patent protection and individual property rights. It would affect the manufacturing and marketing of medicines, foods, and pesticides.

This would be bad legislation because patent protection stimulates and sustains pharmaceutical research. It is this research which has revolutionized the treatment of diseases.

Patents are individual property and are not monopoly rights. They lead to competition and provide the incentive for further research.

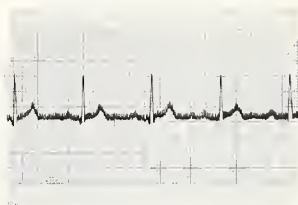
* * *

ECONOMIC BULLETIN IKA, Ankara, Turkey, December, 1964—The prevailing opinion in the Ministry of Health is that the nation's economy would benefit if Turkey imported low-priced drug raw materials from other countries, for instance from Italy. Imitation drug substances imported from Italy are not of the same quality as products available from companies now in Turkey whose parent organizations are in the U. S. and some European countries. The Ministry of Health apparently attaches little significance to the purity of these products if it does import from Italy or other countries where unidentifiable impurities have been observed in some drug items.

* * *

EL DIA, Mexico, January 19, 1965—Javier Rojo Gomez, Secretary General of The National Farmers' Association (CNC) told the press that by putting the chemical and pharmaceutical industry under the effective control of the state, it would become possible to cut unnecessary expenditures and thus enable hospitals to increase the pay to doctors and to other medical personnel.

AC can cause ECG problems



the 500 VISO minimizes AC interference

To help you get *clear*, diagnostically *useful* cardiograms quickly and easily, special circuits in the new 500 VISO effectively cancel the most commonly occurring types of "AC artifacts." And an important companion development which takes advantage of the characteristics of the "500" is Redux *Creme* — easier to apply than an abrasive paste, aesthetically more pleasing to patient and technician alike, less time-consuming from start to finish.

This slim, lightweight cardiograph has two chart speeds, three recording sensitivities, functionally-grouped controls, interior space for all accessories, and other physiologic recording capabilities as well — yet costs only \$695 delivered, Continental U. S. Call Sanborn now for full 500 VISO information. Sanborn Company, Waltham, Massachusetts 02154.



Sanborn Division, 2040 Lincoln Park West, (312) 248-3737
Chicago, Illinois 60614



Rx Reviews

and New Products

FDA ENFORCES KEFAUVER-HARRIS LAW DRUG ADVERTISING REGULATIONS

FDA is now enforcing the prescription drug advertising provisions of the Kefauver-Harris law.

Under the law, prescription drug advertisements are required to show:

1. The "established name" of the drug, if one exists, in type at least half as large as that used for the brand name.

2. The drug's quantitative formula to the extent required on the drug label.

3. A true and nonmisleading brief summary of information about adverse side effects, contraindications, and effectiveness of the drug for the guidance of physicians, as required by the regulations.

In enforcing these requirements FDA will determine whether a fair balance exists between the information on effectiveness and that on side effects and contraindications.

The Bureau of Medicine will monitor professional journal advertising for prescription drugs. It will forward violative advertisements with appropriate recommendations to the Bureau of Regulatory Compliance.

Kinds of copy which may violate the law include:

1. Extension or distortion of the claims for usefulness beyond that approved in the product's final printed labeling.

2. Featuring of a quote from an article in a way which misleads by improperly implying that the particular study is representative of much larger and general experience with the drug.

3. The selection of poor quality research papers making statements favorable to the product while ignoring contrary evidence from more qualified research.

4. Quotation out of context of a seemingly favorable statement by an authoritative figure but omission of adverse data from the same article.

5. Quoting from an obviously authoritative source while failing to quote from other differing experts in the same field resulting in improperly balanced viewpoints.

6. Featuring data from papers that report no side effects, but failing to quote from others that do.

7. Continuing to run ads which are constructed from data previously valid but rendered obsolete or false by more recent research.

Violations will be evaluated in two categories:

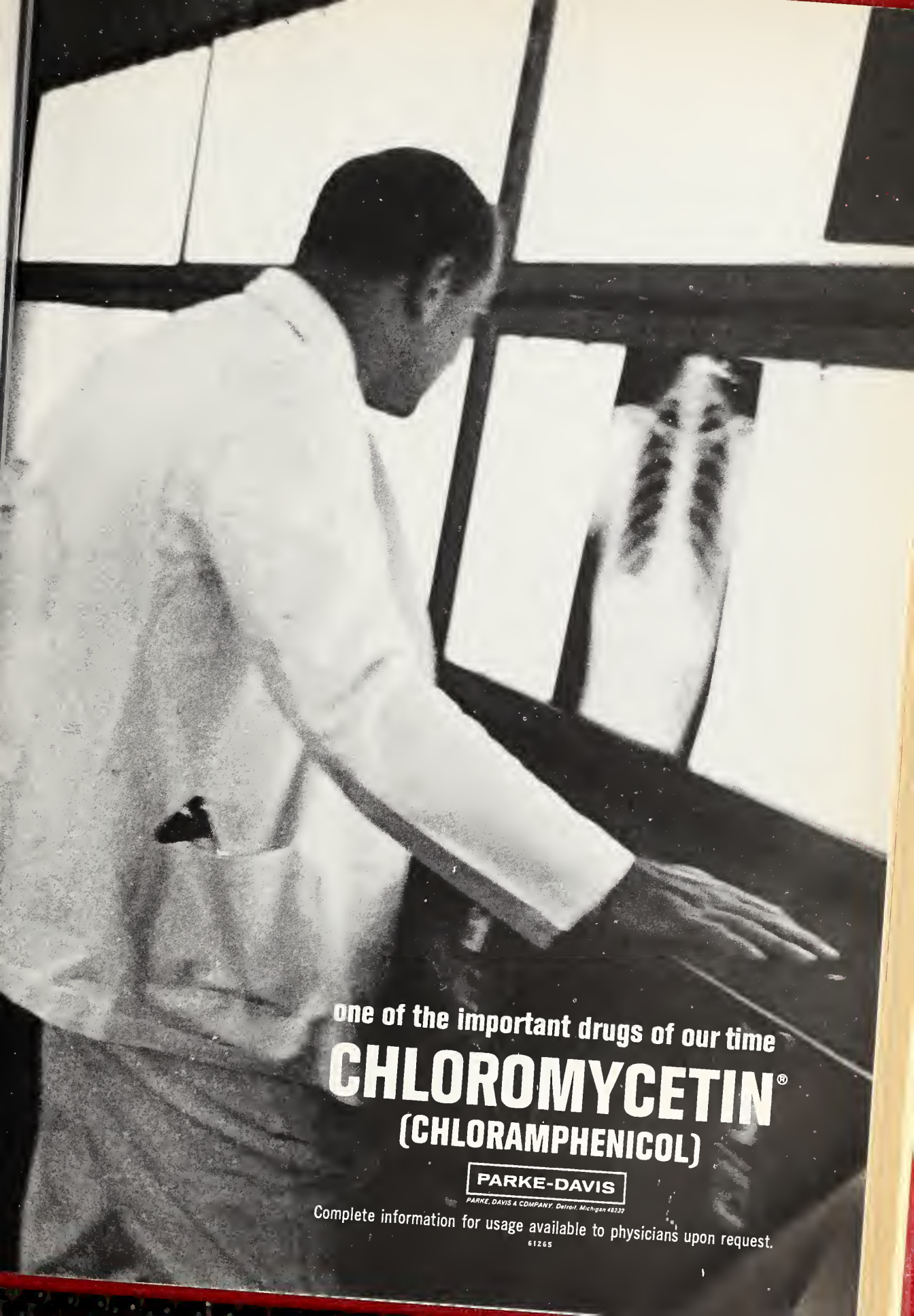
1. Positive claims or omissions concerning the product which present potential danger to the patient in varying degrees. Examples include omission of some of the pertinent side effects, precautions or contraindications; improper statements about the effectiveness of, or indications for, the drug or antibiotic; omission of some of the information on various dosage forms, ingredients, or directions for use where required.

2. Claims which may or may not involve danger to patient health but which, in the selling message, can seriously mislead as to the proper place of the drug or antibiotic in the total spectrum of products available to meet a specific disease situation.

While high priority will be given to cases presenting the most serious health hazard to the consumer, FDA will not disregard the second category and will maintain a balanced program to assure the practicing physician that he will receive accurate information about prescription drugs from the pharmaceutical industry.

The Bureau of Scientific Standards and Evaluation, through its Division of Antibiotics, will furnish scientific evaluation to the Bureau of Medicine in matters concerning bacteriology, chemistry or related disciplines with respect to antibiotic drug advertising. It may also recom-

(Continued on page 508)



one of the important drugs of our time

CHLOROMYCETIN[®]

(CHLORAMPHENICOL)

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

Complete information for usage available to physicians upon request.

61265

Rx Reviews (cont'd)

mend to the Commissioner a course of action involving the certification services where illegal advertising of antibiotics is involved.

The Bureau of Education and Voluntary Compliance will continue to answer, through its Advisory Opinions Branch, specific questions from industry regarding prescription drug advertising. The Bureau will determine through these questions, and by consulting with the Bureau of Medicine, what areas are of such general interest that they warrant a formal educational approach to the pharmaceutical companies, their advertising agencies or both. It will develop educational materials, utilizing assistance from those industries where possible.

The Bureau of Regulatory Compliance will initiate corrective actions as required to deal with prescription drug advertising that constitutes a threat to the public health or in other ways constitutes a serious violation of the advertising provisions of the Kefauver-Harris Drug Amendments.

COURT RULES AGAINST GOVERNMENT IN "FOLK MEDICINE" LABELING CASE

The Court of Appeals for the Second Circuit, New York, ruled against the Government on November 18, 1964 in a review of the condemnation by a district court of Sterling Vinegar and Honey charged misbranded by the books—"Folk Medicine" and "Arthritis and Folk Medicine," by D. C. Jarvis, M.D. The books advanced the theory that vinegar and honey are of medical value for a long list of diseases and conditions.

The district court had ruled that the books, which made false statements about the health merits of the product, were labeling which misbranded it since the claimant, Balanced Foods Inc., intended to use the books to promote the vinegar and honey as a medicine. The firm had both the books and the product in its warehouse and "health food" outlets.

The appellate court held that while labeling includes the written matter upon any article or any of its containers or wrappers and the written matter accompanying such article, it does not include every writing which bears

some relation to the product. The distinguishing characteristic of labeling is that, in some manner or another, it is presented to the customer in immediate connection with his view and his purchase of the product, the court held.

The appellate court further stated that the Government failed to show that Balanced Foods or any of their retailers ever promoted either the books or the article together. Thus, they concluded, there was no basis for finding that Balanced Foods did more than carry two related products. Since there was no immediate connection with the sale of the product at either the retail or wholesale level, the lower court's decision was reversed. It has not been decided whether the decision will be appealed by the Government.

BCG AVAILABLE

BCG Vaccine, a standardized preparation of BCG bacillus in the dry form for use in immunization against tuberculosis, is being made available by Eli Lilly and Company. It is produced by Glaxo Laboratories Ltd., of England.

The vaccine has been used successfully to control tuberculosis in England and other countries for several years. It is prepared from a Glaxo substrain of a Danish strain of BCG bacillus.

The initials BCG are derived from the name of the organism, tubercle bacillus, and from the names of the two men responsible for the isolation and attenuation of the original strain, Drs. Albert Calmette and Camille Guérin, of the Pasteur Institute of France.

In line with its policy of supplying the broadest line of biological products, the company offers BCG Vaccine to interested physicians in the public health and other fields.

Considerable laboratory and clinical evidence has demonstrated a large reduction in the incidence of tuberculosis in vaccinated persons as compared with nonvaccinated tuberculin-negative controls.

The segment of the American population in

(Continued on page 510)

to help relieve pain
in common
anorectal disorders

“non-caine” Diothane[®]

Diothane—with its chemically distinct “non-caine” anesthetic agent dipiperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

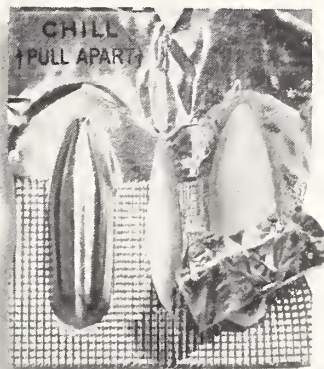
DIOTHANE OINTMENT

COMPOSITION:

dipiperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:

Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.



DIOTHANE SUPPOSITORIES

COMPOSITION:

Each suppository, weighing approximately 2.6 Gm., contains dipiperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:

Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario

Rx Reviews (cont'd)

which BCG vaccine is indicated has been defined by the American Trudeau [Thoracic] Society as follows:

1. Children living in areas with a high prevalence of tuberculosis among the younger age groups and certain adults living in highly special situations.
2. Physicians, nurses, medical and nursing students, and laboratory personnel.
3. Persons unavoidably exposed to continued contact with infectious cases of tuberculosis in the home.
4. Patients, inmates, and employees of institutions, such as mental hospitals and prisons, in which case-finding programs indicate the exposure to tuberculosis is likely to be high.

The Committee on the Control of Infectious Diseases, American Academy of Pediatrics, has advised BCG vaccine for all children whose risk of exposure to active pulmonary or renal tuberculosis is high. This is in accord with the recommendations of the Tuberculosis Control Advisory Committee of the U.S. Public Health Service.

BCG vaccine is contraindicated in tuberculin-positive individuals, in individuals on long-term corticosteroid therapy, and in those with disorders in which the natural immunologic capacity of the host may be adversely affected by disease processes. A standard skin test for tuberculin sensitivity, given within the six-week period preceding vaccination, is a necessary precaution.

BCG vaccine's protection against tuberculosis is only relative and is not permanent or entirely predictable.

The vaccine is reconstituted by adding 1 cc. of Sterile Water for Injection to each 1-cc.-size multiple-dose ampoule of vaccine. It is allowed to stand for approximately one minute. Shaking is avoided because it produces foaming. The process of withdrawing the liquid from the ampoule will yield a homogenous suspension.

The immunizing dose is 0.1 cc., injected intradermally. After reconstitution, the ampoule should be used immediately, with any remaining material being discarded.

Normally a small red papule appears at the injection site within seven to ten days after vaccination. The top of the papule scales, ulcerates, and dries. This usually heals to a pink or bluish scar in approximately three months and to a white scar in approximately six months.

Too deep an injection may cause ulceration. Occasionally, infection of the lymph vessels from the site of injection and the swelling of lymph glands have been observed. Rarely, abscesses may develop in the regional lymph nodes draining the site of the BCG vaccination. Secondary infection can cause skin abscesses at the injection site. On occasion granulomas, appearing approximately four to six weeks following vaccination, have been seen at injection sites.

BCG Vaccine is supplied in a 1-cc.-size package (V-991). It should be stored in a cool place, between 35° and 50°F., and should be protected from light.

INJECTABLE SYNTHETIC THYROID

Synthroid (sodium levothyroxine), a synthetic thyroid hormone, is now available in injection form for intravenous administration from Flint Laboratories.

It is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required or when oral therapy is inadvisable.

The intravenous use of sodium levothyroxine produces a predictable increase in PBI concentration, eliminates the need for multiple doses until oral therapy can be reinstated.

Synthroid Injection is supplied in lyophilized form in a 10cc vial containing 500 mcg. of active ingredient. A 5cc vial of sodium chloride diluent is also provided. The lyophilized form is completely stable and assures maximum absorption. Synthroid Injection acts in hypothyroidism, as does endogenous thyroxine, to stimulate metabolism, growth, development and differentiation of tissues. It increases the rate of energy exchange and increases the maturation rate of epiphyses.

(Continued on page 512)



YOUR PROFESSIONAL EQUIPMENT...

**a major investment on
which you EARN NO
interest or NO dividends.**

It's true. The thousands of dollars which you have invested in equipment vital to your practice are unproductive dollars.

UNELCO has developed an equipment sale-leaseback program for you which you should investigate.

Under this program you can free unproductive capital and put it to work in areas that can prove to be highly profitable. Also, you'll enjoy all the other monetary and tax benefits associated with business leasing.

UNELCO

**101 South Wacker Drive
Chicago, Illinois 60606
312/726-0804**

The coupon is for your convenience. Go ahead. Clip it. Many people make a living from coupon clipping. Or phone...

UNELCO • 101 South Wacker Drive • Chicago, Illinois 60606

Please telephone me to discuss your sale-leaseback program for doctors. This inquiry places me under no obligation and, of course, is held in the strictest confidence.

NAME: Dr. _____

STREET: _____

CITY: _____ STATE: _____

TELEPHONE: _____ BEST TIME TO CALL: day _____ time _____

4

Rx Reviews (cont'd)

Flint Laboratories, a producer of specialty pharmaceuticals, is a division of Baxter Laboratories, Inc., Morton Grove, Illinois.

STEROID INJECTIONS USEFUL IN MANAGING LOW BACK, LEG PAINS

Spinal injections of a steroid hormone relieved almost two-thirds of a group of patients with persistent low back pain and leg pain problems, a new clinical study of 48 patients indicates.

"Their level of complaint was materially reduced and they were able to return to former activity," said Dr. Ernest W. Mack, Reno, Nevada, of the patients who responded successfully to this treatment. Their conditions, while debilitating, were not severe enough to warrant surgery.

In routine treatment, Dr. Mack used 40 mgs. of methylprednisolone acetate (Depo-Medrol) combined with 50 mgs. of procaine hydrochloride. Intrathecal injection of these drugs through a spinal needle produced good results in 33 (70%) of the patients, fair results (50% improvement in symptoms) in 5 other patients, and poor results in 10.

The method will relieve persisting post-surgical low back and leg complaints in about 60 per cent of cases. It is not difficult, and may be used either in the office or hospital, Dr. Mack reported in *Rocky Mountain Medical Journal*.⁹

After injections, patients were kept in the office for about two hours. When analgesia was achieved, sciatic stretching was carried out to at least a normal range of motion. Wherever possible, patients were instructed to ambulate and to carry out movements sustaining a full range of back motion and leg motion.

Myelograms were done whenever examination and history indicated that this was desirable. If findings from the myelogram were negative, the intrathecal injection was given and the same routine of sciatic stretching was carried out.

The commonest side effect—occurring in 15 patients—was transient soreness and aching of the low back which usually disappeared within 24 hours after treatment and which, Dr. Mack

said, was not of major significance.

Faintness and weakness, coccygeal pain, and fluid retention were also reported in a few patients. One major complication was encountered in an elderly man who had a circulatory collapse a few minutes after the injection. "He required strenuous treatment and was subsequently kept overnight in hospital," the clinician reported.

In 29 instances, only one injection was used with 22 good and 7 poor results. The period between multiple injections varied. In 7 cases it was one week; in 5, two weeks; in 8, one month; and in 7, two months.

Broad-Spectrum Antibiotic

Keflin® (cephalothin, Lilly), a new broad-spectrum bactericidal antibiotic is being introduced by Eli Lilly and Company.

The new antibiotic is an injectable which will be used mostly in hospitals. Because of its high degree of safety and demonstrated effectiveness against a variety of both gram-positive and gram-negative organisms, Keflin is particularly recommended by clinicians for initial therapy in patients seriously ill with infections caused by organisms not yet identified.

In the clinical studies Keflin has frequently been lifesaving in infections resistant to other antibiotics. It has been of particular value in treating patients whose renal function is known to be reduced—a condition in which other antibiotics may be less desirable or contraindicated.

Keflin is an antibiotic of an entirely new chemical class. It was developed in the Lilly Research Laboratories by reaction of thiophene-2-acetic acid with 7-aminoscephalosporanic acid. The cephalosporanic nucleus is obtained from cephalosporin C, which is produced by the fungus *Cephalosporium*. Keflin is supplied as the sodium salt of 7-(thiophene-2-acetamido) cephalosporanic acid.

The new antibiotic is bactericidal against both gram-positive and gram-negative organisms in concentrations that are only slightly greater than those required by bacteriostatic

(Continued on page 514)

in maintenance therapy...

a working analgesic for the active arthritic

ARTHRALGEN®

Each tablet contains:

Salicylamide.....	250 mg.
Acetaminophen.....	250 mg.
Ascorbic acid (Vitamin C).....	25 mg.

a working analgesic for the active arthritic

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

two proven pain relievers

Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

sodium-free

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.¹

ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

Salicylamide.....	250 mg.
Acetaminophen.....	250 mg.
Ascorbic acid (Vitamin C).....	25 mg.
Prednisone.....	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.²

A. H. ROBINS COMPANY, INCORPORATED/RICHMOND, VIRGINIA

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.
2. Cohen, et al.: J.A.M.A., 165:225, 1957.

action. It destroys bacteria by inhibiting cell wall synthesis.

Thus far in the clinical experience with Keflin, it has been used successfully in treating the following clinical conditions:

Respiratory Tract Infections—Follicular tonsillitis or septic sore throat, bronchopneumonia, pneumonia, empyema, and lung abscess caused by group A beta-hemolytic streptococci, pneumococci, *Klebsiella*, *Hemophilus influenzae*, or coagulase-positive staphylococci.

Urinary Tract Infections—Acute and chronic pyelonephritis, cystitis, and asymptomatic bacteriuria caused by pathogenic strains of *Escherichia coli*, paracolon bacilli, *Aerobacter*, or *Proteus*.

Soft-Tissue and Skin Infections—Furunculosis, abscesses, and wound infections with cellulitis, symbiotic gangrene, and pyoderms caused by pathogenic strains of coagulase-positive staphylococci and group A beta-hemolytic streptococci.

Gastro-Intestinal Infections—Bacterial gastroenteritis due to *Salmonella* and strains of *Shigella*.

Other infections—Osteomyelitis and septicemia caused by coagulase-positive staphylococci and gram-negative bacteremias due to the colon bacillus and *Proteus*.

Pseudomonas organisms are notably resistant to Keflin. Relative resistance against the antibiotic's in-vitro action is shown by enterococci (*Streptococcus faecalis*).

Since Keflin is not absorbed following oral administration it cannot be given by mouth in treatment of systemic infections.

Antibiotics should be given with caution, and then only when absolutely necessary, to any patient who has demonstrated some form of allergy, particularly an allergy to drugs. No exception should be made with respect to Keflin.

Three instances of neutropenia and low white-cell count in patients receiving Keflin have been reported by one investigator, with the circumstances indicating a causal relation-

ship. The blood counts returned to normal after withdrawal of the antibiotic.

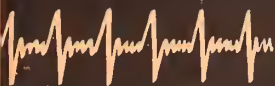
Each gram of Keflin is supplied as a dry powder in 10-cc. rubberstoppered ampoules (No. 698) for reconstitution with 4 cc. of Sterile Water for Injection. The reconstituted material will provide two 0.5-Gm. doses of 2.2 cc. each. If smaller volumes are used for dilution, Keflin will not go into solution. Solutions should always be stored in the refrigerator. There they may change color without significant loss of potency. Also, they may precipitate but can be redissolved by being warmed.

Keflin may be given either intramuscularly or intravenously. In patients who are poor risks because of lowered resistance and present or impending shock, intravenous therapy may be mandatory.

When given intramuscularly Keflin should be injected deeply into a large muscle mass, such as the gluteus, to minimize pain and induration. The usual dosage range in adults is 0.5 to 1 Gm. every four to six hours. A dosage of 0.5 Gm. every six hours is adequate in uncomplicated pneumonia, furunculosis with cellulitis, and most urinary tract infections. In severe infections, dosage may be increased by giving the injections every four hours, or when the desired response is not obtained, by raising the dose to 1 Gm.

The dosage in infants and children should be proportionately less in accordance with age, weight, and severity of infection. Daily administration of 50 mg. per Kg. (40 to 80 mg. per Kg. or 20 to 40 mg. per pound) in divided doses has been found effective for most infections susceptible to Keflin.

The intravenous dosage also ranges from 2 to 6 Gm. daily for adults. When intermittent administration is desired, 0.5 to 1 Gm. in 10 cc. of normal saline solution is slowly injected directly into the veins over a period of three to four minutes or is given through the tubing when the patient is receiving parenteral fluids. Continuous infusion is obtained by adding the daily dose to the daily volume of fluid being administered intravenously.



ISMS, CMS to Host Future Physicians, Wives at First Annual Student AMA Conference

The First Annual Student American Medical Association Conference—sponsored by the Illinois State Medical Society and the Chicago Medical Society—will be held Saturday, May 1, at Chicago's LaSalle Hotel.

Invitations have been sent to more than 1,000 SAMA chapter members representing all of Chi-

cago's five medical schools, it was announced by Dr. Hilger Perry Jenkins, chairman of the ISMS Advisory Committee to SAMA.

"The purpose of the conference," said Dr. Jenkins, "is to give the academic communities of all five schools an opportunity to participate together in a learning session typical of many conducted for physicians by the medical profession throughout every year."

Sessions will begin at 4:30 p.m. with an address on "The Physician as a Good Samaritan—Legal and Moral Aspects" by Edwin J. Holman of the American Medical Association's Law Department and former director of the AMA De-

partment on Medical Ethics.

Following will be an address on "Medical Decisions and Spiritual Considerations" by The Rev. Dr. Elam Davies of the Fourth Presbyterian Church, author of a chapter on that subject in a medical text on surgery.

The assemblage will adjourn for a social hour preceding dinner. Highlight of the evening will be the banquet address on "Quackery" by Dr. Morris Fishbein.

Deans of the medical schools have been invited to the conference as honored guests and wives of students are being encouraged to accompany their husbands from beginning to end of the program.

Collinsville Surgeon Makes Rounds of 9 Hospitals Via Copter



Collinsville surgeon Dr. Obert M. Lay has solved the time and transportation problems in serving nine hospitals in seven Illinois cities. Dr. Lay earned a federal helicopter pilot's rating before purchasing a two-seater helicopter in December. He's presently working out landing areas and doesn't believe the coming and going of the craft will disturb the quiet of hospital areas. Dr. Lay is believed to be the first surgeon in the midwest to travel between hospitals by helicopter.

County Society Secretaries Meet to Plan Better Service to Physician, Community

Physicians from throughout the state attended a grass roots meeting of the medical profession on Sunday, April 4, in Springfield.

The day-long session at the St. Nicholas Hotel was called by the Illinois Medical Society for the physicians who serve as elected secretaries of its 93 component county societies.

The conference explored ways in which county societies could provide better service to their members and improve public health in their communities.

Delegates gave special attention to health care legislation now being considered in Washington. Among the featured speakers were Ray C. Dickerson, immediate past president of the Illinois State Chamber of Commerce and co-

chairman of the Citizens for Elderly Care Committee.

A behind-the-scenes analysis of congressional activity on the administration's Social Security health plan was given by Dr. F. J. L. Blasingame, executive vice president of the American Medical Association.

Another major topic was the future of the physician-population ratio in downstate Illinois.

In addition, the secretaries discussed new action programs and policy measures to be submitted to the House of Delegates of the Illinois State Medical Society at its 125th annual convention May 16-19 in Chicago's Sherman House.

Dr. Alfred A. Zanette of Chicago presided as chairman of the conference.

10 Students Get Nod From Medical Loan Panel

Ten premedical students, who agreed to practice in rural Illinois upon completion of their training, have received recommendations necessary for acceptance into the University of Illinois College of Medicine in Chicago. Four of the men also were granted loans of \$5,000 each.

Recommendations and loans were granted to Bobby Field, Newton; John Ferrell, Eldorado; David Newton, Rockford; and Richard Froeb, Sycamore.

Recommendations only were granted to Phil Baer, Tremont; John Dawdy, Greenville; William Kidd, Peoria; Donald Bedford, Joliet; James Goodwin, Kankakee; and Max Burnam, Mansfield.

The recommendations and loans were made by the medical student loan fund program sponsored by ISMS and the Illinois Agricultural Association. Purpose of the medical student loan fund program is to encourage young men to become general practitioners and to locate in small towns in Illinois where a shortage of doctors exists.

Thirty-one students applied for the recommendations or loans and were interviewed by the committee at the IAA home office in Bloomington on February 3.

Each participant in the medical student loan fund program must agree to serve as a general practitioner in an Illinois community of 5,000 population for five years after receiving training.

Medical Assistants Slate Annual Parley

The Illinois Medical Assistants Association will hold its Ninth Annual Convention April 23-25 at the Holiday Inn in East Peoria.

Featured will be a major address on Eldercare by Dr. Lorin D. Whittaker, member of the ISMS Committee on Public Affairs.

Other highlights of the convention will include the induction of Mrs. Shirley Kleinschmidt of Elgin as president, who succeeds Mrs. Corinne Berg of Sycamore, and the election and installation of officers.



Members of the medical student loan fund committee are shown at their recent meeting in Bloomington where they interviewed 31 students applying for recommendations or loans for medical school. The committee members are, from left, (seated) Roland King, director of the ISMS Division of Business Services; Roy E. Will, assistant secretary of the Illinois Agricultural Association; Dr. Jack Gibbs, chairman of the committee; (standing) Dr. Thomas Bunting, member of the ISMS Rural Health and Student Loan Fund Committee; Harold E. Hartley, IAA vice president; William Steinert, IAA director; and Merle Jeffers, IAA director.

Sangamon Auxiliary Fashion Show Nets Donation to State Benevolence Fund.



Mrs. Franklin Yoder, left, presents a check for \$400 from the Sangamon County Medical Society auxiliary to Mrs. Willard Scrivner, state auxiliary president, as a contribution to the Benevolence Fund. Looking on is Mrs. Victor Beinke, county president. The donation was made possible by a fashion show conducted by the Sangamon auxiliary under the chairmanship of Mrs. Yoder.

League for Nursing Slates Regional Recruitment Parleys

Recruitment for nursing will be the focus of three regional institutes to be held Saturday, April 24, at the Pere Marquette Hotel in Peoria; Saturday, May 15 at the Copley Memorial Hospital in Aurora; and Saturday, May 22, at the Holiday Inn in East St. Louis.

The meetings have been planned especially for nurses in physicians offices, in school health services and in public health nursing services because of their unique opportunities to interpret nursing through their community contacts, according to Mrs. Kay Bailey, executive director of the Illinois League for Nursing, Inc.

Each of the programs, to run from 9:00 a.m. to 3:30 p.m., will include current facts about the need for more nurses, nursing education programs in Illinois and sources of nursing information available to potential students and the public.

A registration fee of \$2.50 will include lunch. For information, contact the Chairman of the Committee on Careers in Nursing, Illinois League for Nursing, 6355 North Broadway, Chicago, (Phone BR 4-8692).

Nominating Committee Lists Slate to Offer Auxiliary Convention

The Nominating Committee of the Woman's Auxiliary to the Illinois State Medical Society will present the following slate of officers to the house of delegates of the auxiliary at its annual meeting in May:

Mesdames John Koenig, president; Newton DuPuy, president-elect; Alden Rarick, vice president of program; Allen S. Watson, vice president of community service; Samuel G. Plice, vice president of benevolence; Glen Harrison, treasurer; Sherman Arnold, corresponding secretary; and Willard Scrivner, Burtis Montgomery and George Pastnack, board members.

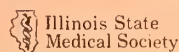
Members of the nominating committee include Mesdames Matthew Uznanski, chairman; Fred Endres, Harold Dubner, Donald Nellins and John Ovitiz.

ISMS Uses Billboards to Promote Vaccine Immunization Against Polio



Don't take a chance on polio

TAKE POLIO VACCINE



"Don't Take a Chance on Polio—Take Polio Vaccine" is the April theme in the Illinois State Medical Society's preventive medicine billboard campaign. The message on the above poster—which can be seen on more than 150 billboards throughout the state—is dramatized by additional publicity materials for radio, television and newspapers. This month's promotion on polio immunization is made possible by the cooperation of Lederle Laboratories.

Auxiliary Board Members Tackle Top Issues at Annual Spring Meeting



Board members of the Woman's Auxiliary to ISMS dealt with a heavy agenda on public affairs, legislation, constitution revisions and convention plans at their annual spring meeting held recently at Chicago's Lake Shore Club. Addressing the day's luncheon were Dr. William E. Adams, chairman of the ISMS board of trustees, and Robert L. Richards, ISMS executive administrator. Shown above, from left, are (seated) Dr. Adams; Mrs. Willard C. Scrivner, state auxiliary president; Richards; (standing) Mrs. Glenn Harrison, auxiliary hospitality chairman; and Mrs. Sherman C. Arnold, an auxiliary director.



Mrs. Willard C. Scrivner
President

Auxiliary Convention Program

Lures Record Attendance

REGISTRATION **MEZZANINE** **SHERMAN HOUSE**
 Sunday, May 164:30 to 10:00 P.M.
 Monday, May 177:30 A.M. to 4:00 P.M.
 Tuesday, May 187:30 A.M. to 4:00 P.M.
 Wednesday, May 197:30 A.M. to 11:00 A.M.

MONDAY, MAY 17

George Bernard Shaw Room

Formal Opening of the
 Thirty-Seventh Annual Meeting9:00 A.M.
 Mrs. Willard C. Scrivner, President, presiding
 InvocationMrs. Harold McCann,
 St. Clair County
 Pledge to the FlagMrs. Robert R. Hartman,
 Morgan County
 Pledge of LoyaltyMrs. W. J. Wanninger,
 Past President of Woman's Auxiliary to the
 Illinois State Medical Society
 WelcomeMrs. Paul David,
 President of Woman's Auxiliary to the
 Chicago Medical Society
 ResponseMrs. Edward L. Chainski,
 President of Woman's Auxiliary to the
 Lake County Medical Society
 Report of Credentials and Registration Committee,
 Mrs. Holger Hoegh, Chairman
 Reading of the Convention Rules of Order,
 Mrs. Percy Clark, Parliamentarian
 Adoption of Convention Program
 Announcement of Reference Committee Appointments
 Appointment of Committee on Courtesy and Resolutions
 Appointment of Election Committee
 Convention Announcements ...Mrs. Mitchell Spellberg,
 Convention Chairman
 Greetings from the Illinois State Medical Society,
 Burtis E. Montgomery, M.D., Chairman,
 Advisory Committee
 Report of the Bylaw Revisions Committee,
 Mrs. Frederick Roos, Chairman
 Presentation of BudgetMrs. Walter Shriner,
 Chairman
 Presentation of Certificates to Auxiliaries,
 Mrs. James McDonough, Past President of Woman's
 Auxiliary to the Illinois State Medical Society
 Memorial ServiceMrs. Harold McCann,
 Councilor of 10th District
 Pin & Gavel Club12:30 P.M.
 "Galley & Grog" Marina City,
 Mrs. Matthew Uznanski, Chairman

OPEN HOUSE

President Suite Hospitality 3:00 to 4:30 P.M.
 ChairmanMrs. Glen Harrison
 Vice ChairmenMrs. Edward Cannady,
 Mrs. Frank Brundza
 4:00-5:00 P.M.—County Presidents & Councilors Meet
 with Incoming President & President Elect—
 Ruby Room

"Night on the Town"

Dinner, Athens Restaurant7:00 P.M.
 Sightseeing Tour of Old Town,
 Buses leave Sherman6:30 P.M.
 ChairmanMrs. John Koenig
 Vice ChairmenMrs. Sherman C. Arnold,
 Mrs. Paul David, Mrs. Joel Mossberg,
 Mrs. Kenneth Stegman

SECOND DELEGATE SESSION

TUESDAY, MAY 18

Continental Breakfast Workshop

George Bernard Shaw Room8:00 A.M. to 9:15 A.M.

ChairmanMrs. Thomas Kelso
 Vice-ChairmanMrs. Randolph Olmsted
 9:20 A.M.—IntroductionMrs. Harlan English,
 Past President of Woman's Auxiliary to the
 American Medical Association
 AddressCivic Responsibility—
 Mrs. Richard A. Sutter, President-elect of Woman's
 Auxiliary to the American Medical Association
 Introduction of CouncilorsMrs. John Koenig
 County Presidents Reports

LUNCHEON AND FASHION SHOW

Luncheon Jacques 12:30 P.M.
 HonoringMrs. Richard A. Sutter,
 President-elect of the Woman's Auxiliary to the
 American Medical Association
 Fashion Show Blum's Vogue 2:00 P.M.

THE ANNUAL DINNER

Illinois State Medical Society
 Grand BallroomSherman House
 County Presidents, Hostesses
 Hospitality Hour7:00 P.M.
 Dinner8:00 P.M.
 in honor of Edward A. Piszczek, M.D., President

WEDNESDAY, MAY 19, 1965

George Bernard Shaw Room—8:30 A.M.

Parliamentary "Know-How" for "Early Birds"
 Mrs. Percy Clark, Parliamentarian

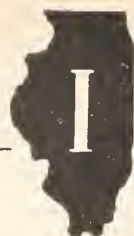
THIRD DELEGATE SESSION

9:00 A.M.

Mrs. Willard C. Scrivner, presiding
 Report of Courtesy and Resolution Committee,
 Mrs. Carl E. Sibilsky
 Report of Credentials and Registration Committee,
 Mrs. Holger Hoegh
 Reference Committee Reports
 Officers and DirectorsMrs. Matthew Uznanski
 CouncilorsMrs. Glen Marshall
 Standing CommitteesMrs. Alden Rarick
 Action for the Budget for 1965-1966,
 Mrs. Walter Shriner
 Report of Nominating Committee,
 Mrs. Matthew Uznanski
 Election of Officers
 Election of Delegates to the Annual Meeting of the
 Woman's Auxiliary to the
 American Medical Association
 Continuation of County Presidents Reports,
 Mrs. John Koenig
 Introduction10:40 A.M.
 Mrs. Newton DuPuy
 Address "Stronger Than the Atom"10:45 A.M.
 Dr. Nicholas Nyaradi
 New Business
 Convention Announcements

INSTALLATION LUNCHEON

Bal Tabarin Sherman House 1:00 P.M.
 Honoring
 Mrs. Willard C. Scrivner, Retiring President; Mrs.
 John Koenig, Incoming President, and Past State
 Presidents, Woman's Auxiliary to the Illinois State
 Medical Society
 Installation of OfficersMrs. James McDonough
 Installing Officers
 HostessesWoman's Auxiliary to the
 St. Clair County Medical Society
 ChairmanMrs. Edward Szewczyk
 Vice Chairmen ..Mrs. Philip Astor, Mrs. Wilson West
 ProgramStrolling Musicians



Special Honor to Dr. Hirsch



Dr. Hirsch

In appreciation for his many years of leadership and outstanding service to the profession of medicine and specifically to the field of pathology, Dr. Edwin F. Hirsch was elected Honorary Member of the Chicago Pathological Society in special ceremonies January 11.

Over a period spanning more than 35 years of service, Dr. Hirsch's performance as teacher, physician and author has established him as one of the true giants in the field of pathology. An Emeritus Professor at the University of Chicago since 1950, Dr. Hirsch also holds a long and distinguished record as Professor of Pathology at Rush Medical College. He is the author

of over 200 publications, including the text "Pathology in Surgery" (1953) published by Williams and Wilkins. The text is considered a classic in its field.

To countless practicing physicians in the Chicago area, Dr. Hirsch may best be known for his outstanding achievements as Director of the Henry Baird Favill Laboratory, St. Luke's Hospital, Chicago. It was in this capacity that he was responsible for the training of generations of pathologists.

Dr. Hirsch is a past president of the Chicago Medical Society and past president, vice president and secretary of the Chicago Pathological Society. Currently, the Illinois Medical Journal is honored to claim him as a member of its editorial board.

Appointments

Dr. A. Scribner has been appointed to the newly-created position of medical director of the Glenbrook Laboratories Division of Sterling Drug, it was announced by J. N. Cooke, Jr., vice-president of Sterling and president of Glenbrook.

Dr. Scribner was senior associate director of medical research for Winthrop Laboratories, another Sterling Division, before assuming his present position. He was associated with Winthrop since 1946 as assistant medical director and associate medical research director.

After receiving a B. S. degree from Yale University's Sheffield Scientific School, he obtained an M.D. from Columbia University College of Physicians and Surgeons. He served his internship and residency at New York City's St. Luke's Hospital before entering private practice.

Dr. Scribner is a member of the American Medical Association, New York State and County Medical Societies, the New York Acad-

NEWS and ANNOUNCEMENTS (Cont'd)

emy of Medicine and the Association of Medical Directors.

* * *

John C. Watson, a former Jacksonville, Illinois, minister, has been officially appointed Director of the Illinois Department of Registration and Education. He had been serving as Acting Director since December 7, 1964 when former Director William S. White resigned to assume duties as Circuit Judge in Cook County. Prior to that Watson was Assistant Director of the Department.

Succeeding Watson as Assistant Director of Registration and Education is Ira T. Dawson, of Chicago, a nephew of U.S. Congressman William Dawson. A former Assistant Corporation Counsel for the City of Chicago, Dawson is district finance chairman, Chicago Area Council of the Boy Scouts of America.

The new R & E Director has worked closely with ISPE on numerous complaints filed by the Illinois Society against non-registered practitioners. A native of Clay County, he received his college education at McKendree College in Lebanon and at Illinois College in Jacksonville.

* * *

Three physicians on the faculty of the University of Illinois College of Medicine in Chicago have been appointed or elected to national professional positions recently.

Dr. Paul H. Holinger has been elected to the Board of Regents of the American College of Surgeons. Dr. Holinger is a professor of bronchoesophagology in the Department of Otolaryngology.

Dr. Gerald O. McDonald has been appointed to the Advisory Committee on Institutional Research Grants of the American Cancer Society for a three-year term. Dr. McDonald, associate professor of surgery, has also been elected to the board of directors of the Illinois Division of the American Cancer Society's Chicago Unit.

Dr. Adrian M. Ostfeld has been appointed a member of the Council on Epidemiology of the American Heart Association. Dr. Ostfeld is a professor of preventive medicine.

Dr. Carl T. Nelson, New York, N.Y., has been named President of the American Academy of Dermatology—world's largest organization of skin disease specialists.

Dr. Nelson, 56, is Professor of Dermatology at Columbia University's College of Physicians and Surgeons.

Selected as vice-president of the Academy, which held its 23rd Annual Meeting last week at the Palmer House Hotel here, was Dr. Harry L. Arnold, Jr., Honolulu, Hawaii, chief of dermatology at the Straub Clinic.

Newly elected to the 15-man Board of Directors were Dr. Herman Beerman, Philadelphia, Pa.; Dr. Everett C. Fox, Dallas, Tex.; Dr. E. Richard Harrell, Ann Arbor, Mich.; Dr. Frederick D. Malkinson, Chicago, Ill. and Dr. Morris Waisman, Tampa, Fla.

Re-elected to offices were: Dr. Stanley E. Huff, Evanston, Ill., Secretary-Treasurer; Dr. Robert A. Pommerening, Seattle, Wash., Assistant Secretary-Treasurer and Dr. Samuel J. Zakon, Chicago, Ill., Historian.

Dr. Harry Dowling, professor of medicine and head of the Department of Medicine at the University of Illinois College of Medicine has been named to a special nine-man Medical Advisory Board to aid the Food and Drug Administration of the Department of Health, Education and Welfare.

During his appointment which became effective March 2 Dr. Dowling and the other Board members—all experts in the fields of medicine, pharmacology, dentistry and veterinary medicine—will advise the Department on the programs, policies and problems it faces to enable it to reach decisions that are in the best interests of consumers and the medical profession.

The Board will also make recommendations on the development of new FDA programs and will advise the commissioner of the Food and Drug Administration on trends and advances in medical and related biophysical sciences; on attitudes and opinions of the medical scientific community; and on recruitment and training of physicians and associated scientists in FDA.

The Advisory Board is scheduled to meet four times a year, in Washington, D.C.

In other action, Dr. Adrian Ostfeld, professor of preventive medicine, University of

Illinois College of Medicine, has been appointed vice-chairman of the Council of Epidemiology of the American Heart Association.

He has also accepted the chairmanship of the Human Ecology Study Section of the National Institutes of Health.

* * *

Harry Davis, former public relations director of Forest Hospital in Des Plaines, has been appointed head of a new division of the Herbert M. Kraus and Associates public relations firm, located at 75 East Wacker Drive. Mr. Davis will be director of Hospital Public Relations and Education. In his new post he also will be in charge of a branch office in Des Plaines, located at 672 Pearson Street.

Former Director of public relations for the Illinois Hospital Association, Mr. Davis has written extensively on problems of communications and is the author, also, of two books on World War II, "Fighting for America" and "This is It."

Previously, he served as publicity director for the Jewish Federation of Metropolitan Chicago.

New Films

A new medical motion picture, "Why Blood Volume?", produced by Ames Company, Inc., Elkhart, Indiana, was shown for the first time to physicians at a special premiere at Beth Israel Hospital, Boston, Massachusetts.

The film was produced under the supervision of Dr. Jacob Fine, Surgeon-in-Chief, Beth Israel Hospital and Professor of Surgery, Harvard Medical School. Dr. Fine also narrates the film. The film is designed to show physicians and medical personnel a new improved technique using VOLEMETRON, the original automatic electronic blood volume computer, manufactured by Ames Atomium, Billerica, Massachusetts.

Accurate measurement of a patient's blood volume has challenged physicians for nearly half a century and past methods for measuring

(Continued on next page)



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the volume of blood were slow, cumbersome and inaccurate. Only recently, with the use of VOLEMETRON, have techniques been so improved and simplified that blood volume determinations can be made rapidly. The film depicts common clinical situations where measurement of blood volume should be performed.

"Why Blood Volume?" stresses that blood volume measurements help the surgeon during surgery by accurately determining how much blood is lost, and after surgery, by detecting concealed blood loss of excessive loss of blood plasma. The film points out that blood volume determinations are useful for assessing: the need for transfusion; the type of transfusion; and the amount of blood required. Blood volume measurements are also valuable in preventing over-transfusion. The film concludes that new needs for blood volume determinations will constantly be uncovered as experience is gained with the use of VOLEMETRON.

The 25-minute, sound, color motion picture is available for showings without charge to medical groups and organizations through Ames Film Department, Elkhart, Indiana.

* * *

"Medifilm Report VI," a 32-minute filmed report of highlights of the 113th Annual Meeting of the American Medical Association in San Francisco, is now available from Schering Laboratories.

Produced in association with the AMA's Department of Medical Motion Pictures and Television, the 16 mm., black and white sound film features scientific exhibits, lectures and panel discussions. Host-narrator is Roberto F. Escamilla, M.D., of San Francisco.

Subjects covered include: clinical applications of Laser light (Dr. Milton Flocks, Palo Alto, Calif., and Dr. Paul E. McGuff, Boston,

Meeting Memos



May 1-2—A one and one-half day seminar on Chronic Obstructive Lung Disease will be presented at the Medical College of Georgia, Augusta. Five nationally known teachers will discuss recent developments related to this problem. The program is planned to be of interest to all physicians. A registration fee of \$5.00 will be charged. Information concerning details of the program, registration, etc., may be obtained by writing to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

June 4-5—Northwestern University Medical School in cooperation with The Cook County Post Graduate School of Medicine presents Current Management of Burns at the Cook County Graduate School of Medicine.

Attendance will be limited, and registrations

will be considered in the order received. For further information, write the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612.

July 4-10—The Second European International Seminar will be held at Oxford University, London, England. The theme of the seminar is "New Horizons In Rehabilitation" with special reference to Cardiac Surgery, Cardiac Medicine, The Role of the Day Hospital, Prostheses—their Future, Domiciliary, Social, Transport & Building Standards Industry and Sheltered Employment, and The Employer and the Handicapped. Exhibitions, films and study tours will be included. Reservation Forms on application to The General Secretary, B.C.R.D., Tavistock House (South), Tavistock Square, London, W.C.1.

Mass.); cardiac telemetry (Dr. Herbert J. Semler, Portland, Oreg.); simplified intestinal biopsy (Dr. James B. Carey, Jr., Minneapolis, Minn.); an excerpt from a new teaching film on "Normal Delivery," prepared under the guidance of AMA and the American College of Obstetricians and Gynecologists; and mental retardation (Dr. Charles H. Carter, Orlando, Fla.).

Other topics are: renal homotransplantation (Dr. David H. Hume, Richmond, Va.); a panel discussion on "High Oxygen Pressures in Medicine" (Dr. Christian J. Lambertsen, Philadelphia, Pa., moderator); intermittent peritoneal dialysis (Dr. Kevin G. Barry, Washington, D.C.); cancer chemotherapy—regional perfusion (Dr. Oscar Creech, Jr., New Orleans, La.); and cancer chemotherapy—ambulatory infusion (Dr. Elton Watkins, Jr., Boston, Mass.).

A print of "Medifilm Report VI" may be obtained by writing to the AMA at 535 North Dearborn Street, Chicago 10, Ill., or to the Audio-Visual Department, Schering Corporation, Union, N.J.

A CARE, INC. film about MEDICO personnel in Malaysia has been released to television stations for free showings through the film libraries of Modern Talking Picture Service.

The 13½-minute film is called "The Greatest Gift." It shows how the doctors and nurses of MEDICO, a service of CARE, have "given of themselves in fullest measure" to meet the medical challenge of a country where superstition and the influence of medicine men and herbalists must be overcome before the sick can be properly healed.

"The Greatest Gift" shows how these dedicated men and women have won the confidence and respect of the people and brought to Malaysia not healing alone but the education and training of local medical personnel, and to the people themselves the basics of personal hygiene and good health. MEDICO personnel fly by helicopter into the otherwise inaccessible villages of the Malaysia jungle to work with the aborigines, who not only have never seen

(Continued on page 524)

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 BLOOD VESSEL SURGERY, One Week, May 10
 HAND SURGERY, One Week, May 3
 MANAGEMENT OF BURNS, Two Days, June 4 & 5
 SURGERY OF STOMACH, One Week, June 14
 GALLBLADDER SURGERY, Three Days, June 14
 SURGERY OF HERNIA, Three Days, June 17
 COLON SURGERY, One Week, May 24
 FRACTURES & TRAUMATIC SURGERY, Two Weeks, June 7
 GYNECOLOGY, Office & Operative, Two Weeks, June 7
 GYNECOLOGICAL MALIGNANCIES, One Week, May 24
 ADVANCES IN MEDICINE, One Week, May 3
 BOARD REVIEW COURSE IN MEDICINE, Part II, June 14
 HEMATOLOGY, One Week, June 14
 GENERAL PRACTICE REVIEW, One Week, May 3
 CLINICAL ENDOCRINOLOGY, One Week, June 7
 ADVANCES IN PEDIATRICS, One Week, May 10
 DIAGNOSTIC RADIOLOGY, Two Weeks, May 10
 ANESTHESIA, Inhalation, Endotracheal, Regional,
 Request Dates

*Information concerning numerous other
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NEWS and ANNOUNCEMENTS

(Continued)

a doctor in their lives but live and dress as they did a hundred years ago.

CARE is the Cooperative for American Relief Everywhere, Inc., a non-profit agency for voluntary assistance to needy people in other lands. It is registered by the Advisory Committee on Voluntary Foreign Aid of the Agency for International Development, U. S. Department of State, but its funds depend entirely on contributions from individuals and organizations.

Another CARE film was released to television stations through Modern Talking Picture Service recently. It is "By Their Bootstraps," a report on technological and economic aid to a little Panamanian fishing village.

Miscellaneous

Washington, D.C.'s public health birth control program, operating "under the eye of Congress" with a Congressional appropriation, sets an "important precedent" which could have "implications on the national level," Dr. Murray Grant, Director of Public Health in the District of Columbia, said last month.

Addressing a Planned Parenthood-World Population Annual Meeting luncheon at New York's Hotel Roosevelt, Dr. Grant characterized family planning as "an integral part of an attack on poverty" but warned that "continued pressure" would be necessary before birth control services comparable to Washington's might be expected to develop in tax-supported institutions elsewhere in the country.

Recognition of how involuntary parenthood intensifies the health problems of the poor and increases public health and welfare costs prompted the District of Columbia Health Department to launch its public program last April, Dr. Grant said.

"There is, of course, no question of the close relationship which exists between poverty and birth control," he asserted. "It is clear, for example, that many women who have large families because of their lack of knowledge concerning family planning are the women whose families end up on public public assistance rolls. It is also true to say that as a result of

these repeated pregnancies some of these women develop health problems which are costly to correct and which often require tax funds."

Health aspects of birth control are of considerable importance, Dr. Grant added, because many families in the poverty bracket have been advised not to have additional children for health reasons but "simply have not had either the know-how or wherewithal to accomplish this objective even if they have the desire."

Washington's program, launched last April with a \$25,000 Congressional appropriation, has already gained wide acceptance, Dr. Grant stated. More than 1200 patients enrolled in the first six months of operations and a "considerable waiting list" developed for the services offered on a voluntary basis at six clinic locations. "The program was established to promote maternal health by means of child-spacing, to provide information on the availability and advantages of birth control, to furnish advice and supplies to voluntary participants, to provide medical supervision and follow-up and to collect and evaluate data," he pointed out.

The department has already asked for a doubled appropriation in its next year's budget request which includes funds for the establishment of a full-time birth control team and for broadened eligibility, he announced. At present eligibility is limited to mothers referred by the District Welfare Department; mothers who have just delivered babies at the District General Hospital, and patients attending post-partum clinics. Patients are offered a choice of oral pills, foam, diaphragm and rhythm. The newest birth control method—intrauterine contraceptive devices—may be added "in the near future" according to Dr. Grant.

Commenting on the national significance of the Washington program, Dr. Grant said that the fact that Congress did appropriate funds for this specific purpose "sets an important precedent" and the fact that the program "is operating directly under the eye of Congress could also have important implications on the national level."

Dr. Grant's assessment of national prospects for public health birth control came as he reviewed the Washington project's origin. Giving major credit to a campaign by Planned Parenthood's Washington Affiliate—Planned Parent-

(Continued on next page)

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NEWS and ANNOUNCEMENTS

(Continued)

hood of Metropolitan Washington, D.C.—he added: "I am equally certain that it is going to take the same continued pressure in other parts of the country to create an interest in its development elsewhere," he concluded.

Planned Parenthood-World Population is the national voluntary organization fostering citizen and government action in support of population and birth control in the United States. Approximately 500 delegates from all over the nation are attending the Annual Meeting.

* * *

The Executive Committee of the Illinois Association of Blood Banks announced today its affirmation of the American Medical Association's resolution on blood banks. In a meeting held at the Webster Hotel, the Executive Committee voted unanimously in favor of the AMA House of Delegates' resolution which calls for "the approval of the county or district medical society" before new blood banking facilities are established in a community.

Dr. James B. Hartney, Chairman of the Executive Committee of the Illinois Association of Blood Banks, said, "It is essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county medical society and should be coordinated with existing approved blood banking facilities, prior to their being established in a community. Doctors are in the best position to establish and maintain the standards necessary for high quality in blood. It is their medical knowledge which stands between the public need and the possibility of inferior blood procurement and supply."

The Illinois Association of Blood Banks represents 83 Hospital and Community Blood Banks in Illinois.

* * *

A wide variety of new informational and promotional materials is available to medical societies and physicians who need help in publicizing existing diabetes detection drives or in organizing new ones in their communities.

Details of the assistance program are described in a pamphlet, "An Effective Program of Year-Round Diabetes Detection in Your Community," available on request.

The pamphlet includes a "case history" in which the Essex County (New Jersey) Medical Society played a key role in mobilizing many other interested groups to produce a highly successful diabetes detection program in East Orange.

These special promotional materials are provided as a public service by The Upjohn Company. A unique feature of the material is that the separate elements can be adapted to include the name of the local medical society and other community groups sponsoring the program.

A key element is a dramatic diabetes detection film in 5-minute and 1-minute versions suitable for showing in movie houses, on TV, and at club meetings. The name of the medical society or other local sponsoring group may be inserted at the end of the film.

Other materials include:

- A special folder for physicians on "Screening and Diagnosis in Diabetes Mellitus," a handy reference describing in detail the principal testing methods. Sufficient copies can be made available for mailing to each member of the local medical society.

- Counter display cards for pharmacies and other business establishments bearing the legend: "Are You a Hidden Diabetic?"

- Consumer leaflets, which can be distributed separately or inserted in a pocket on the display card, challenge the reader to check himself for symptoms of diabetes.

Local and county medical societies, local diabetes detection committees, and other interested groups may have sample copies of the descriptive brochure and other promotional literature on request. Write to: Diabetes Detection, 342 Madison Avenue, Room 914, New York, N.Y. 10017.

(Continued on page 528)

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NEWS and ANNOUNCEMENTS

(Continued)

Legislation to prevent racketeers, "fast buck artists," and other undesirable elements from building and operating hospitals was introduced today (Thursday, February 25) in Springfield.

Principal sponsor of the bill is Senator Arthur R. Gottschalk (R., Park Forest, District 8). Twenty-nine other senators from both parties are co-sponsors.

The bill would amend the state Hospital Licensing Act to require sponsors of all new hospital projects to obtain a permit before they could proceed with plans for construction. They would need to demonstrate that they have the "qualifications, background, character, and financial resources to adequately provide a proper standard of hospital service for the community." Sponsors would also be required to demonstrate that the proposed hospital would "meet a need that is identifiable in the community."

Beyond what he termed the "obvious need to keep our Illinois hospital system under the control of responsible community leadership," Senator Gottschalk said the bill would help to control the inherent waste in building hospital facilities in areas where they are not needed.

* * *

America's first manned two-man spacecraft was equipped with drugs which were used in flight or after landing.

Medical experts at National Aeronautics and Space Administration chose the drugs after testing to make sure they would withstand space flight and be effective and safe for use by astronauts.

Six types of drugs were aboard the Gemini—an anodyne and an analgesic (pain relievers); an antiemetic (to relieve or prevent nausea); an analeptic (to restore consciousness in coma or fainting); an antibiotic and an antimalarial. Drugs would be administered in flight only on orders of a ground-based flight surgeon.

The drugs can be administered either by mouth or by automatic injection in the leg through the space suit. All are contained in both in-flight and survival kits, except the anti-malarial which is available only in the survival kit.

The automatic AstroPen injector consists of a light weight cylinder, a half inch in diameter and four inches long, with a smaller, spring-loaded, needle-tipped tube within it holding the vial of medicine in place. Pushing the outer tube releases the spring, shooting the needle through a small opening and forcing a plunger in the vial to inject the drug.

Injectable drugs which were available to the astronauts are Tigan brand of trimethoprim benzamide HCl, for nausea or vomiting due to motion sickness, reported to have a minimal sedation effect; and Demerol brand of meperidine HCl, to relieve pain.

Drugs for oral use will include Tigan in capsule form; Dexedrine brand of dextro-amphetamine sulfate for use against chronic fatigue, depression, or as an appetite depressant; Demerol in tablet form; an aspirin-phenacetin-caffeine pain reliever product; Achromycin, a tetracycline antibiotic; and Aralen, a chloroquine phosphate antimalarial preparation.

The spacecraft will also carry water purification tablets.

A drug was used once previously by an American in space, when Astronaut Gordon Cooper administered a stimulant to himself 78 minutes before his relatively difficult manual re-entry into the atmosphere.

All of the drugs have undergone severe physical environmental tests by NASA to assay their ability to withstand temperature, pressure, vibration and other factors. Manufacturers, in preparing the drugs, have conducted rigid tests for quality control, safety and effectiveness. Injectable drugs have been sterilized both before and after loading into the automatic cartridges. The injectables were manufactured by two pharmaceutical companies and processed by a third in its Marietta, Pa., laboratory.

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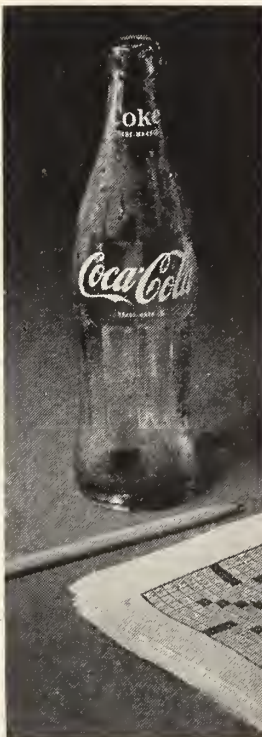
for information contact: **Milton A. Dushkin, M.D.**
MEDICAL DIRECTOR



11:47 pm



11:53 pm



12:06 am

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Obituaries

Howard C. Ballenger*, Winnetka, died March 3, aged 78. A physician and surgeon for 50 years, he retired in 1961. Doctor Ballenger was chairman emeritus of the E.N.T. department of Northwestern University's Medical School.

Andrew F. Barnett, Tempa, Florida, formerly an Illinois physician, died March 2, aged 57. A graduate of the University of Illinois College of Medicine in 1932, he specialized in orthopedic surgery.

Aaron O. Broyde*, Oak Park, died March 6, aged 73. In 1921 he was a graduate of the Ekaterinoskv Medical Institute, Dnepropetrovsk, U.S.S.R. He retired in 1963 and was an emeritus member of ISMS.

Charles H. Daugherty, Alton, died February 23, aged 40. A graduate of Bowman Gray School of Medicine of Wake Forest College, North Carolina, in 1951, he specialized in psychiatry. He was on the staff of Alton State Hospital at the time of death.

Leo B. Ginsburg, Chicago, died March 25, aged 72. He was a graduate of Chicago College of Medicine & Surgery in 1914.

Nordahl O. Gunderson*, Madison, Wisconsin, formerly of Rockford, died February 20, aged 77. A graduate of Northwestern University Medical School in 1916, he retired in 1959. Dr. Gunderson organized the Winnebago County Health Department and was named consultant until his death. He was also an emeritus member of ISMS.

Leroy H. Harner*, Norwood Park, died February 22, aged 78. A graduate of the University of Illinois College of Medicine in 1914, he was on the staff of the Chicago Board of Health for 20 years prior to his retirement in 1963.

Green B. Hart*, Harrisburg, died November 23, aged 82. In 1913 he graduated from the Chicago College of Medicine and Surgery and he retired in 1959.

James B. Holmes, Sr., Belleville, died March 1, aged 54. A graduate of the University of Colorado School of Medicine in 1943, he specialized in obstetrics and gynecology.

Daniel W. Jeffries*, Chicago, aged 75, died March 25 at Swedish Covenant Hospital where he had been a staff member since 1947. In 1916 he graduated from Jenner Medical College. He was an emeritus member.

Paul Z. Koesun, Chicago, died March 10, aged 73. He was a graduate of Northwestern Medical School in 1922 and he practiced medicine for over 35 years. In 1963 he was given the Civic Achievement Award for his contributions to the Chinese-American communities.

Ross S. Lang*, Chicago, died November 28, aged 70. In 1922 he was a graduate of the University of Toronto Faculty of Medicine, Toronto, Canada and he was an emeritus member of ISMS.

Robert T. McElvenny, Chicago, died March 27, aged 60. A graduate of the University of Colorado School of Medicine in 1932, he specialized in orthopedic surgery. He was senior attending surgeon at Wesley Memorial Hospital. A diplomate of the American Board of Orthopedic Surgery, he had taught bone and joint surgery at Northwestern Medical School since 1945.

George J. Mohr, Chicago, died March 6, aged 68. A graduate of Rush Medical School in 1919, he specialized in child psychiatry. He was active in his field in Chicago for years until he moved to California in 1961.

Marshall D. Molay*, Chicago, died March 15, aged 78. A graduate of Bennett Medical College in 1912, he specialized in pathology until his retirement in 1959. He was a member of the Fifty Year Club of ISMS.

Robert E. Ransmeier*, Murphysboro, died March 8, aged 87. A graduate of Northwestern University Medical School in 1901, he was an instructor at both Northwestern and Rush during his years of practice. He was both an emeritus member and a member of the Fifty Year Club of ISMS.

William H. Rubovits*, Chicago, died March 17, aged 86. A graduate of Northwestern University Medical school in 1900, he specialized in obstetrics and gynecology. He had been on the staff of Michael Reese for over 40 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Thomas I. Stines*, East St. Louis, died January 25, aged 77. In 1911 he was a graduate of the St. Louis University School of Medicine. A member of the Fifty Year Club of ISMS, he retired in 1960.

Charles G. Wright*, Evanston, died February 11, aged 92. In 1899 he graduated from Rush Medical College and practiced both medicine and dentistry in Chicago for over 60 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

*Indicates member of Illinois State Medical Society.



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Illinois Medical Journal

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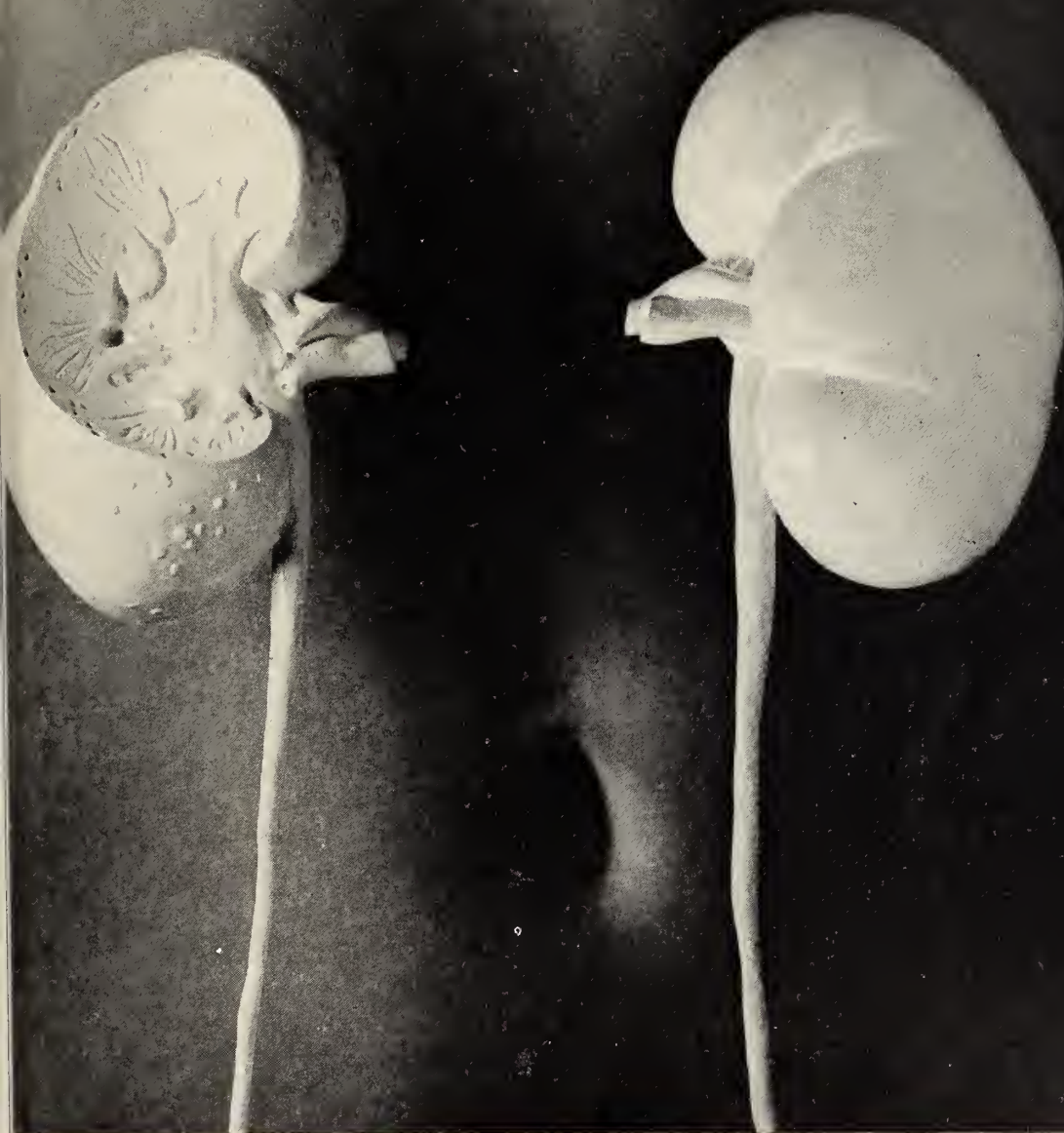
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Edward A. Piszczek, M.D.

president's page

1965: OUR FINEST HOUR

IT has been said that communications are the beginning of understanding . . . and understanding, the basis of progress. On that premise I am especially pleased to inaugurate this new channel of communications between the members and first officer of the Illinois State Medical Society.

As one of my last official communiques as ISMS president, it is only fitting that I should document and summarize the actions of our society during my tenure. Certainly, the most significant and far-reaching of these actions was our heroic battle against Medicare.

We have lost all but the final phases of that battle. There is no denying it, nor is there comforting solace in the fact that we fought resourcefully, energetically, devotedly, and—above all—honestly. Instead of these empty commiserations, we have far more tangible and purposeful values which we can attach to the struggle just completed.

First, it can stand permanently as a glowing example of what we believe in and against which we continue to pledge our opposition. Secondly, the energies and unity of purpose which it called up from each and every one of us can continue to work for the system of medical care we cherish so highly and to which we have declared ourselves so courageously.

There are several ways in which these energies can be utilized. First, they can be converted to active participation in legisla-

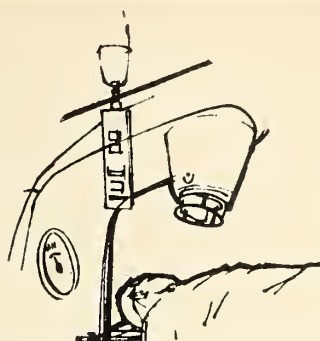
tive and public affairs at the local level by every physician in our state. Only through such continued activity can we hope to guard the prognosis of our profession against further intrusion by the malignancy of welfare control. Secondly, they can be used to hold up our ideals clearly before the public, so that when the sham and waste of federalized medicine are finally realized, American citizens will have a ready and recognized alternative to revert upon.

Keeping the sparks of our ideal alive, so that once again they may kindle, is no easy task. Yet, with faith in our cause, with dignity, and with resoluteness of purpose, it can be accomplished.

To my worthy successor, Dr. Burtis Montgomery, I consequently do not bequeath a year of self-pity and despair, but one of repair and reaffirmation. I bequeath to him further active public affairs programming of such magnitude that it will shake the structure of federalized medicine to its very foundations. Of each and every physician in Illinois, I ask that they rally 'round Dr. Montgomery, offering their full measure of cooperation and personal effort in these endeavors.

Let us show throughout the next year that although we have lost a battle, the final victory shall be ours. To paraphrase a famous statesman, let us henceforth conduct ourselves so that—if our profession sustain a thousand years—it shall always be said of us, "This Was Their Finest Hour."

Medical Progress



HARVEY KRAVITZ M.D. /progress editor

CLINICAL SIGNIFICANCE OF SPECIFIC FINDINGS IN ELECTROENCEPHALOGRAPHY

PART 1 OF A
4 PART SERIES

F. A. Gibbs, M.D., and E. L. Gibbs/chicago

Introduction

Electroencephalography is commonly helpful for estimating the extent and degree of damage caused by cerebral trauma or brain infection, for determining the type and location of epileptic processes, and for localizing space occupying lesions when these involve the outer convexity of the cerebral hemispheres. Although the factual basis of electroencephalography cannot be compressed into a single essay and although a small series of illustrations cannot show all the details of pattern and the special features of the tracing that are important for diagnosis and localization, it seemed worthwhile to attempt to provide a key to the clinical implications of the major electroencephalographic findings. Physicians who refer patients for electroencephalograms need to know, and have a right to know, what the electroencephalographer means when he reports certain

abnormalities. In order to save space, bibliography and documentation are largely dispensed with in this presentation. The statements made here are based on a detailed analysis of thousands of cases, an analysis which has been presented in full in the first, second and third volumes of the *Atlas of Electroencephalography*.¹⁻³ Those wishing extensive references to the original literature will find them in the bibliographies to these three volumes.

Technique

Certain technical conditions must be met in order to make an electroencephalogram maximally informative. Abnormalities commonly appear in sleep that are not present in the waking state; the reverse is also true. If the recording does not include at least 10 minutes of waking activity and all stages of sleep, down to the spindle-mixed-with-slow phase, it is an incomplete study. A minimum of an hour is usually required for a high quality waking-sleeping electroencephalogram. Some electroencephalographers explain that they use sleep when "necessary." However, no one can decide in advance when sleep is necessary.

Efforts to activate the electroencephalo-

Professor of Neurology, University of Illinois College of Medicine, Chicago, Illinois.

Research Assistant, Department of Neurology, University of Illinois College of Medicine, Chicago, Illinois.

gram by the use of Metrazol or photic stimulation have not been especially rewarding; the results cannot be validated for diagnostic purposes^{4,5}. These activation methods are gradually being abandoned in favor of a more passive approach in which the electroencephalographer waits through a long, waking-sleeping recording for the brain to reveal its defects.

To facilitate the recording of sleep activity the patient is asked to come to the laboratory after having had less than the usual amount of sleep the night before (4 hours of sleep for adults, and 6 for children). Caffeine containing beverages are not to be taken for 8 hours prior to the test. Anticonvulsants or other therapeutic agents can be continued, but should be reported.

Sleep is obtained more readily if small, disc-electrodes are attached to the patient's head with a quick drying glue and connected by fine wire to the junction box. Needle electrodes, clips and head-gears of various types interfere with the patient's comfort and make it difficult to obtain sleep. If drowsiness or sleep patterns do not appear in the first half-hour of recording the patient is given a dose of a sedative drug and the dose is repeated if the patient is awake at the end of an hour.

Tracings are made from electrodes placed in the ten locations from which specific patterns of activity are usually obtained in the waking and sleeping states and in pathological conditions. These are the left and right frontal, mid-temporal, anterior temporal, parietal (central), and occipital areas. Two reference electrodes are placed on the patient's ear-lobes and elsewhere as needed. Additional electrodes are applied as, and where, needed. The so-called "International 10-20 System of Electrode Placement" wastes electrodes by placing them where they are not ordinarily needed (particularly in the pre- and post-central areas) and it omits electrodes where they are essential (in the anterior temporal areas).

Electroencephalographers have been divided over the advantages of monopolar (common reference recording) vs. bipolar recordings. All the findings that are con-

TABLE 1.
MAJOR OR EXCLUSIVE ELECTROENCEPHALOGRAPHIC FINDINGS IN 38,082 ROUTINE, CONSECUTIVE REFERRED CASES

E.E.G. FINDING	NUMBER OF CASES
Hypsarhythmia	664
Pseudo petit mal discharges	99
Petit mal variant discharges	192
Grand mal discharges	133
Diffuse nonspecific seizure discharges	611
Petit mal discharges	1,688
6/sec. spike-and-wave discharges	1,071
Multiple spike foci	1,655
Hemisphere focus	399
Occipital spike focus	974
Mid-temporal spike focus	1,003
Frontal spike focus	322
Parietal spike focus	390
14 and 6/sec. positive spikes	5,163
Psychomotor variant	208
Anterior temporal spike focus	3,358
Small sharp spikes	1,025
Fronto-parietal spike-and-wave discharges	393
Rare seizure patterns	143
Spike-like discharges	91
Normal	11,787
M-/and U-shaped alpha	50
Persistent alpha	49
Extreme spindles	86
Asymmetry	581
Asynchrony	61
Slightly fast (F-1)	513
Very fast (F-2)	90
Exceedingly fast (F-3)	398
Slightly slow (S-1)	242
Very slow (S-2)	107
Exceedingly slow (S-3) and flat	275
Anterior bradyrhythmia	202
Minimal temporal slow	539
Focal moderately slow (S-2 focus)	271
Focal very slow (S-3 focus)	1,749
Diffuse paroxysmal slow	270
Runs of slow activity	400
Mittens	706
Miscellaneous disordered sleep patterns	124
TOTAL	38,082

sidered here are easily recognizable in monopolar recordings. Probably with sufficient perseverance they could all be recognized in bipolar recordings also, but this type of derivation makes the task more difficult. Monopolar and bipolar recordings both register voltage differences between pairs of electrodes, but bipolar leads register the difference between more-or-less equally active areas, whereas monopolar recordings register the difference between

TABLE 2.
INCIDENCE OF CERTAIN ELECTROENCEPHALOGRAPHIC ABNORMALITIES AMONG 3,476 CONTROL SUBJECTS*

AGE TOTAL NUMBER OF CASES	0-1 770	2-4 726	5-9 692	10-14 384	15-19 285	20-24 196	25-29 79	30-39 116	40-49 89	50-59 76	60+ 63
	%	%	%	%	%	%	%	%	%	%	%
Hypsarhythmia	0	0	0	0	0	0	0	0	0	0	0
Petit mal variant	0	0	0	0	0	0	0	0	0	0	0
Petit mal discharges	0	0	0	0	0	0	0	0	0	0	0
Pseudo petit mal	0.1	0.1	0.1	0	0	0	0	0	0	0	0
Diffuse, nonspecific seizure activity	0	0.3	0.1	0	0	0	0	0	0	0	0
14 and 6/sec. positive spikes	0.4	5.9	15.8	20.8	16.5	8.7	1.3	0.9	0	0	0
6/sec. spike-and-wave	0	0.1	0.9	1.5	2.8	2.0	1.3	1.7	0	0	0
Psychomotor variant	0	0	0	0	0.4	0	0	0.9	0	0	0
Occipital spikes	0	0.8	0.4	0	0	0	0	0	0	0	0
Mid-temporal spikes	0	0.3	0.8	0.5	0	0	0	0	0	0	0
Parietal spikes	0	0	0.1	0	0	0	0	0	0	0	0
Frontal spikes	0	0.1	0	0	0	0	0	0	0	0	0
Anterior temporal spikes	0	0	0	0	0	0	0	0	0	0	0
Small sharp spikes	0	0	0	0	0	1.0	1.3	6.0	7.9	6.5	4.8
Fronto-parietal spike-and-wave	0	0	0	0	0	0	0	0	0	0	0
Hemisphere spikes	0	0	0	0	0	0	0	0	0	0	0
Multiple spikes	0	0	0	0	0	0	0	0	0	0	0
Extreme spindles	0.1	0	0	0	0	0	0	0	0	0	0
S-3 diffuse	0	0	0	0	0	0	0	0	0	0	0
F-3	0	0	0	0	0	0	0	0	0	0	0
Minimal temporal slow	0	0	0	0	0	0	0	0	0	1.3	3.2
S-2 focus	0	0.1	0.1	0	0	0	0	0	0	0	0
S-3 focus	0	0	0	0	0	0	0	0	0	0	0
Runs of slow activity	0	0	0	0	0	0	0	0	0	0	0
Paroxysmal slow activity	0	0.1	0.1	0	0.4	0.5	0	0	0	0	0
Anterior bradyrhythmia	0	0	0	0	0	0	0	0	0	0	0
Mittens	0	0	0	0	0	1.0	2.5	2.6	3.4	2.6	0
Asymmetry	0	0.1	0.1	0	0	0	0	0	0	0	0
Asynchrony	0	0	0	0	0	0	0	0	0	0	0

* Persons without significant diseases, constituting a representative sample of the general "normal" population.

an active area and an area that has been chosen because it is relatively inactive, for example, the lobes of the ears, the chin, the nose, or the neck. The monopolar technique gives the highest voltages and the simplest wave forms. Bipolar recordings scramble the wave forms by superimposing the activity of one brain area on the activity of another, and in such recordings true electrical sign (negative or positive) is not immediately identifiable. As a consequence bipolarists commonly overlook, or disregard, patterns that have been shown to have definite clinical significance (Tables 1 and 2). Some who pride themselves on their eclecticism, because they use both bipolar and monopolar techniques, are primarily bipolarists and are unable to interpret monopolar recordings with facility. The truly expert monopolarist knows that bipolar recordings are cumbersome and confusing, and for this reason he avoids them as completely as possible.

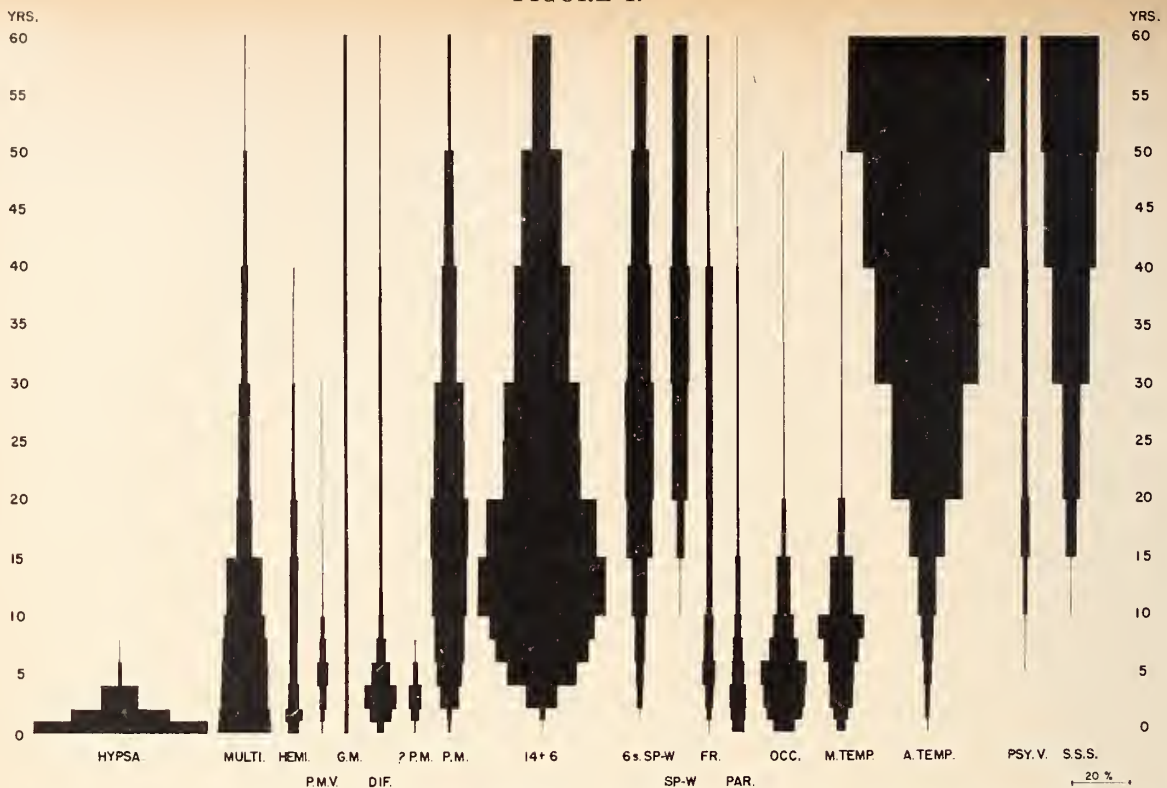
Reporting

Physicians referring patients for electroencephalographic examination should re-

ceive, along with the report of the electroencephalographic findings, a clear statement of what they mean in terms of the case under consideration. This is best conveyed in a face to face discussion between the referring physician and the electroencephalographer, or between the physician and a neurologist or neurosurgeon who is fully aware of the implications of the electroencephalographic findings. In the absence of such a conference an explanatory letter, accompanying the electroencephalogram, is useful.

A valid statistical basis has been established for the utilization of long monopolar, waking-sleeping electroencephalograms for diagnosis and as an aid to treatment. This basis exists because of the systematic classification, tabulation and analysis of a large number of normal and pathological recordings. However, it must be remembered that this basis does not apply to the short bipolar recordings that are standard in many laboratories. At the present time there is very little normative data relating to bipolar recordings at different ages, either awake or asleep. Very large numbers of cases are

FIGURE 1.



This figure is based on 19,350 consecutive cases with spike discharges, classified for age and type of discharge. The percentage incidence of each type in all age groups gives the **age characteristic** of that type of discharge. This is represented graphically as a segment of the total incidence of spikes at a given age; each segment is separated and moved so that it centers over corresponding segments showing the percentage of that type of discharge in other age groups.

The contour of the area above each type of discharge shows the waxing and waning incidence of a particular pattern with age. The 20 percent calibration at the lower right margin allows the width of the column to be read as the percentage incidence of a particular type of discharge in a given age group; for example, 60 percent of persons with spikes, who are below one year of age, have hypsarhythmia, and 65 percent of persons with

spikes, who are 60 years of age or over, have anterior temporal spikes, and 50 percent of children between 10 and 15 years of age who have spikes have 14 and 6 per second positive spikes, etc. Abbreviations are as follows: HYPSA.—hypsarhythmia; MULTI.—multiple foci of spike seizure activity; HEMI.—spikes limited to one hemisphere; P.M.V.—discharge of the petit mal variant type; G.M.—discharge of the grand mal type; DIF.—diffuse non-specific spike discharges; ?P.M.—discharge of the pseudo petit mal type; P.M.—discharge of the petit mal type; 14&6—14 and 6 per second positive spikes; 6sSP-W—6 per second spike-and-wave; SP-W—fronto-parietal spike-and-wave; FR.—spike focus in the frontal area; PAR.—spike focus in the parietal area; OCC.—spike focus in the occipital area; M. TEMP.—spike focus in the mid-temporal area; A. TEMP.—spike focus in the anterior temporal area; PSY. V.—psychomotor variant type of discharge; S.S.S.—small sharp spikes.

necessary in order to clearly delineate the significance of electroencephalographic patterns, as can be seen from inspection of Table 1 and Figure 1. Samples of all the tracings used in this study have been classified into a highly organized matrix, a "brain wave registry," by reference to which it is possible to remove from the area of speculation the normality or abnormality, and the clinical correlates of an electroencephalographic pattern.

Lack of massive data of this character has led many electroencephalographers to feel unsafe about interpreting any abnormalities other than the four or five that are "obvious," for example, delta foci and high voltage negative spikes (in the awake recording). If one considers only such ab-

normalities, electroencephalography is a technique of marginal clinical value. Not more than one-third of epileptics show seizure activity, and a very high percentage of patients with organic brain disease have normal waking electroencephalograms when such "obvious" criteria of abnormality are used. If, on the other hand, awake and sleep recordings with monopolar leads are used, specific types of seizure discharge are found in over 80 percent of epileptics and significant alterations in sleep patterns appear in patients with lesions of the central gray masses and of the brain stem. Only with proper technique and with interpretations based on massive, organized experience, does electroencephalography attain its full usefulness. (*To be continued*)

The Sanatoria of Classical Greece

Thus Spake my Residents, though perhaps more discursively, about the dreads of destruction, desertion and defenselessness (I have since called them our ultimate or "Ur"-anxieties) that have always troubled *Homo sapiens*, and of the compensatory illusions of order, omniscience and omnipotence that have partially comforted him. But before they could graduate with a fourth illusion that, having reached my dotage, I had forgotten that I was supposed to be teaching clinical psychiatry, I set them one more intellectual task, seemingly now less philosophic and more clinical: namely, to learn all they could about the practical methods of medicopsychiatric therapy evolved by man and actually employed, for example, in the Asklepiad Sanatoria of

classical Greece, and in the light of their findings give well-considered answers to the following questions:

First, did not our professional forefathers, being closer to the wisdom of Asklepios and Hippocrates, also understand these Ur-anxieties of Man, and acknowledge their importance in the practice of medicine?

Second, did they not also recognize, two and a half millennia ago, that insofar as a man had lost confidence in himself, his friends and his gods, his anxieties mounted and culminated in an uneasiness properly called dis-ease, characterized not only by somatic vulnerabilities and dysfunctions, but also by various phobias, inhibitions, compulsions, regressions, social maladjustments and even hallucinations and delusions that today we call neuroses and psychoses?

Third, when an ailing and troubled Greek entered one of these Sanatoria, was not his therapy implicitly or explicitly designed to help him regain his equanimity by first, reviving his health and strength; second, improving his relationships with his fellowman, and finally, restoring his beliefs in some cosmic order in which he could feel more secure?

Fourth, and most disconcerting of all to youngsters proud of their exclusive knowledge of the very, very latest psychiatric theories and skills—was there really any method of modern psychotherapy (other than relatively few drugs and medical procedures) that the Greeks hadn't used two and a half millennia ago, perhaps with less theoretical jargon but with greater direct effectiveness?

Again challenged but not deterred (they

MAN'S ETERNAL ANXIETIES AND COMPENSATORY ILLUSIONS

PART 2:
CONCLUDED IN THIS ISSUE

Jules H. Masserman, M.D./chicago

Professor and Co-Chairman of Psychiatry, Northwestern University Medical School.

rarely are), my residents delved into historical tomes (my secretary first typed toms) by Garrison, Zilboorg, Bromberg, Fulton, Riese, Vieth, et al. and, with the growing enthusiasm of historical voyeurs, answered these rhetorical questions as I had anticipated. In effect, they learned that the methods employed in the Asklepiad Sanatoria (named after the son of Appollo, God of music, mind and medicine and therefore the appropriately wise, handsome and harmonious image of every physician) were indeed calculated to mitigate the Ur-anxieties and bolster the Ur-defenses of man as follows:

First, by Restoring Physical Well-being: After the patient had left his contentious home and travelled to one of the Sanatoria in the salubrious environs of Cos, Memphis or Knidos, he was welcomed not by a clerk or social worker but by no less a parent-surrogate than the Head Priest or Priestess, who then further cheered and reassured him by conducting him past piles of discarded crutches and bronze plaques bearing testimonials from grateful ex-patients. Immediate attention was then concentrated on restoring the patient's physical well-being through rest in pleasant surroundings, nourishing and appetizing diets, relaxing baths and massages, and the carefully measured administration of nepenths—drugs that resembled modern ataractics in that they apparently tranquillized both the patient and doctor. Indeed, the Greek word for therapy itself meant service, just as later the Latin *curare*, to care for, gave rise to our term *cure*.

Second, Recultivation of Human Relationships: In accordance with this advance, equal effort was expended in counter-acting the patient's Ur-anxiety of Social Isolation as follows:

Confidence in the Physician: Then as now, the patient was encouraged to relate to his therapist:

First, as a kindly and protective parental figure who provided a source of security and comfort.

Second, as a learned and experienced teacher, whose counsels for more restrained and balanced, and therefore

healthier and happier modes of life could be followed on rational and practical grounds (e.g., as in the various Stoic schools).

Third, as a more personal mentor uniquely interested in the supplicant's complaints ("present illness") and willing to explore their relationship to the patient's past experiences (psychiatric history), their meanings and values (symbolisms) and acquired patterns of goal-directed action (operational analysis), in order that the verbal understandings so derived would lead to more satisfying, lasting and useful adaptations (operational "insight"). Socrates required his students to work through their own verbal perplexities and Plato understood the unconscious significance of dreams and symbols. Aristophanes, in his delightful comedy "The Clouds," pictured the distraught Strepsiades lying on a couch and trying to acquire understanding through fantasy and free-association; less passively, Soranus records the cure of a case of "hysteria" in a virginal bride by a form of direct action that would shock a modern psychoanalyst.

Fourth, the patient-physician relationship (transference) led to an avid acceptance of the efficacy of the physician's quasi-scientific, quasi-mystical remedies. And the arsenal of the Hellenic practitioner included not only medicaments from Cathay to the Gates of Hercules, but also a vast variety of surgical and other manipulations available for the treatment of the weak or ailing, such as the Egyptian practice of trephining the skull and incising the cortex or, as described by Pliny the Elder, subjecting the patient to convulsive therapy by discharging electric eels through the head. We read of Hippocrates' condemnations of the ignorance and superstition inherent in many of these "false remedies" but this alone proves how widely practiced, then as now, they must have been. But in addition to helpful relationships to the physician, the Sanatoria also cultivated:

Group Relationships that included the

following modalities:

The use of *Music*, which provided esthetic expression, encouraged group belongingness through feelings of conjoint rhythm and harmony and led to other advantageous experiences. (I reviewed this in a previous address entitled "Say Id Isn't So—with Music"* beginning with a quotation from Joyce to the effect that "Americans are Jung and easily Freudened"; let us all be thankful that I have no violin or viola at hand now, as I did then, to illustrate what I mean.)

Calisthenics and Dancing, which afforded similar possibilities of reorientative interaction and communion.

Competitive Athletics, not only for the joy of healthy action but for public recognition through nondestructive competition and reward.

Dramatics: Here the poetic psychiatrist (and there can be no other) may well ask: What writings better explore or epitomize basic human relationship than the plays of Euripedes, Aeschylus or Aristophanes? And what productions can offer the patient, either as witness or participant, more varied identifications, vivid experiences or vicarious solutions of his own interpersonal problems. The Greeks cherished and utilized these tragedies and comedies for their deep human empathy and ageless significance, endlessly varied their themes and were personally involved as actors, chorus or affectively moved audience—and thus explored in essence the basic interactions utilized in modern forms of group therapy.

Social Rehabilitation: This offered a transition between a passive dependence on the sanatorium to an eventual recognition of the advantage of a return to the community and service for the common good.

Finally, the Ur-illusion of Transcendent Order: Because they also recognized the necessity of this last belief, even the civil-

ized Greeks demanded that Socrates pay the ultimate penalty for threatening man's trust in the existence of beneficent celestial Beings. To capitalize on this ultimate faith, the Asklepiad Sanatoria, like many hospitals today, were built and operated by one or another religious order which added the following powerful factors to therapy:

(a) A "divinely revealed" doctrine in which all believers could feel an exclusively self-elevating bond of fellowship.

(b) A reassuring ritual which, through its origin in human needs and through millennia of empiric refinement, included such exquisitely gratifying procedures as:

(1) The symbolic eating and drinking of the parent-god's body in the forms of mystically potentiating food and wine (as exemplified in the ancient worship of Melitta and Mithra).

(2) The temple hymns, sung and played in the simple, repetitive hypnotic cadences of a mother's lullaby—and often resulting in "temple sleep"; two thousand years later, Bernheim was to warn "It is a wise hypnotist that knows who is hypnotizing whom." Such escapist trances could then be varied with food, drink and sexual indulgences to be triply enjoyed, since they also honored one's permissive and accommodating gods.

(3) The "anointing" or "laying on of hands" to cure an injured bodily part—a direct reminiscence of the soothing parental stroking of an injured child, as still sought by the emotionally immature avid of chiropractic.

(4) The ethereal, elevating emphasis on the spiritual—a concept as fundamental to life as is the neonate's first breath or *spiritus*. Every human is variously *inspired*, acquires an *esprit de corps*, becomes *dispirited*, and finally *expires* so that his immutable spirit can begin life anew. And here, too, the physician-priest functions in knowing the spiritual World, or purveying professed contrition and remorse to the Spirits of our Fathers, and of requiring only a gratifying small penance with which to avoid the horrors of eternal punishment. Meanwhile, the tem-

*For bibliography see Masserman, J. H., *Principles of Dynamic Psychiatry*, 2nd Ed. Philadelphia, W. B. Saunders Co., 1962.

ple then and now furnished a divinely protected sanctuary from earthly stresses and problems.

(5) And ultimately, the priest also mediates the supreme promise of all religions—or, for that matter, of all “scientific” systems: the conquest, through life eternal, of man’s most grim and implacable enemy of humankind: death itself.

Present—and Now Accounted For

These then, were the ancient—and are the eternal—practices that embody what physicians have intuitively known for centuries: that although no man can ever be *certain* of his health, friends or philosophy, *the illusions of security in each of these spheres are essential to his welfare; and that, all methods of medical-psychiatric therapy are effective only insofar as they restore physical well-being, foster more amicable interpersonal relationships, and help the patient amend his beliefs so as to render them more generally acceptable and useful.* That all of this can be accomplished without impugning a patient’s individuality, infringing on his essential freedoms, or stereotyping his intellect and imagery, is an addendum hardly necessary for this audience.

Today, in the Office

But how can these principles, however well clarified, be applied in “modern” therapy? Let me here try to make explicit the essential techniques I have used in my own practice of neuropsychiatry and psychoanalysis for the past quarter century:

To begin with, if patients are to continue to come to us at all for the comprehensive care they seek, we must regain, cherish and increase the regard the public once had for us not only as skilled technicians but as dedicated humanitarians deserving the highest respect and confidence. Differences of professional opinion, as in any scientific field, are acceptable, but we must face the tragic fact that of late our public polemics, our trade-union image, and our sometimes blatant economic and political partisanship have diminished our stature and impaired the trust we must inspire if we are to serve

our patients to their and our own best advantage. No one of us can alone undertake this essential restoration of our former prestige and influence; it is a task—and an important one—for all of us.

Next, in our direct handling of individual patients, we must discard our cold armor of aloof “professional dignity,” and accept each supplicant not as a diagnostic “challenge,” or a recipient of “specific therapy for the organic pathology” (a repulsive solecism)—and least of all as only another research datum—but as a *troubled human being seeking comfort and guidance* as well as mere relief from physical suffering. These larger requirements should be met in the psychiatric aspects of general medical therapy as follows:

Regardless of whether the patient’s complaints are considered as primarily “organic” or “functional,” bodily discomfort and dysfunction are to be relieved by every medical and surgical means available including, when indicated, carefully prescribed sedatives and hypnotics temporarily useful to dull painful memories, relieve apprehension and quiet agitation. In my own research studies and in my clinical experience, I have found that the barbiturates, bromides, aldehydes and other well-tested drugs, when wisely used, are often preferable to many of the widely promoted but dubious “ataractics” and “tranquillizers”; however, in nearly all medical and surgical specialties we recognize that such surcease, usually of mixed suggestive and pharmacologic origin, is merely the first stage of therapy. As soon as the patient’s tensions and anxieties have abated sufficiently to make him more accessible and cooperative we must strive to re-evoke his initiative, restore his lost skills, and encourage him to regain the confidence and self-respect that can come only from useful accomplishment.

But since no man is an “Islande unto Himself,” the wise physician, whatever his specialty, has a broader task: to recognize that his patient may be deeply concerned about sexual, marital, occupational and other problems that may also

seriously affect his physical and social well-being. This involves an exploration, varying in depth and duration but always discerning and tactful, of the attitudes and values the patient derived from his past experiences, his present goals and tribulations, his effective (normal), socially ineffective (neurotic) or bizarrely unrealistic (psychotic) conduct, the ways in which these patterns relieve or exacerbate his current difficulties, and whether they are accessible to various other methods of medico-psychiatric therapy. It is customary at this juncture for the psychiatrist to warn his colleagues in other fields off his supposedly esoteric preserves; instead, let me confess that it has been my gratifying experience that in most cases any intelligent, sensitive physician can, in time easily available to him, conduct the essential psychotherapy required. In essence, this will consist of using gentle reasoning, personal guidance and progressive social explorations to help the patient correct his past misconceptions and prejudices, abandon infantile or childlike patterns of behavior that have long since lost their effectiveness, revise his goals and values, and adopt a more realistic, productive and lastingly rewarding ("mature") style of life. In this skillfully directed re-education (good psychotherapy, despite a recent fad to the contrary, is about as "non-directive" as good surgery) the enlightened cooperation of his family, friends, employer or others may, with the patient's consent, be secured and utilized to the full. By such means the patient's second Ur-defense will be strengthened by renewed communal solidarity and security—a *sine qua non* of comprehensive treatment.

Lastly, and to mitigate the third, or existential Ur-anxiety, the patient's religious, philosophic or other convictions, instead of being deprecated or undermined, should be respected and strengthened insofar as they furnish him with what each of us requires: a belief in life's purpose, meaning and value. In this fundamental sense, medicine, being a humanitarian science, can never be in

conflict with philosophy or religion—since all three seem to be designed by a beneficent providence to preserve, cheer and comfort man—and thereby constitute a trinity to be respected by any physician deeply concerned with man's health and sanity.

Indeed, with respect to these latter terms, it is of historic-philologic significance that the term *sanatos* implied to the ancients the indissolubility of physical and mental functions (*mens sanis in corpora sano*); so also, our more "modern" word "health" can be traced to the Anglo-Saxon *hal* or *hol*, from which are derived not only physical *hale-ness* and *healing*, but the greeting "*Hail friend!*", and the concepts of *wholeness* and *holiness*. Once again Greek, Roman and Gaul have bequeathed to us, in the rich heritage of a syncretic language in which "reality" and "illusion" merge, their recognition of the indissoluble trinity of physical, social and philosophic components of health and sanity.

History Teaches that History Cannot Teach Us—and Yet . . .

With so many consistencies between past and present, can we also extrapolate the future? Let us group a few predictions about man's behavior around our now familiar categories.

Survival: Despite the perennial legends of Pandora, Golem, Frankenstein et al. in almost every mythology—and the knowledge that we now have at hand enough nuclear explosives to kill every man, woman and child on earth ten times over, I doubt—I *must* doubt—that our race is really hellbent on suicide. Rather, in our frenetic quest for scientific and technical mastery we shall discover dimensions and forces yet unconceived and perhaps better not known; we shall distill the ocean and desiccate its fish for tasteless food; we shall conquer cancer and induce new diseases; we shall explore the moon and find it a dust heap; in short, we shall continue to match our puny efforts against a universe ever beyond man's finite ken or control—and probably be more bewildered and frustrated than ever by the endless and inscrutable cosmos.

Ur-society in the Future: A world community, possibly with outposts* in space, is the only alternative to Armageddon, and since *Homo sapiens* is a single, universally fecund species, differences of "race" or "color" will eventually become about as indistinguishable as Lombard, Hittite or Etruscan strains are now in their mixed Mediterranean descendants. The inhabitants of this earth will certainly become more alike—and perhaps, out of sheer necessity, a little friendlier.

Ur-theology of the Future: Finally, men will develop a deeper sense of purposive existence that will transcend the symbolic legends, rituals and theocracies of our current religions further than we have progressed from the animistic worship of our savage ancestors. And when we achieve this breadth of vision and depth of understanding, we may also become humbler, kinder, wiser—and perhaps a bit happier. Here, however, a final contrapuntal reflection may be in order: since all man's perceptions and derived concepts are essentially subjective, why call the beliefs we have here considered universal "illusions" at all since we live, and shall continue to live by them?

Summary

In summary, then, man's Ur-anxieties

are three: first, his abhorrence of physical injury and death; second, his uncertainty as to the reliability of his human alliances; third, his utter rejection of the thought that perhaps he is, after all, little more than a cosmic* triviality. It is equally significant that these triple trepidations of man also motivate his principal modes of presumed mastery. His maneuvers are here again three: first, his attempt to subjugate his material milieu through various sciences and technologies, including medicine (Ur-defense I); next, his efforts to guarantee his social relationships by familial, economic and political compacts (Ur-defense II) and finally, his endeavors to encompass the entire universe in his philosophic and religious systems (Ur-defense III). Unfortunately, as we know, his strivings in all of these modalities often fail, whereupon he becomes our impatient patient and calls upon us not only as physicians, but also as his friends and ministers to serve him in corresponding modes of therapy. These, predictably, are again tripartite: first, the restoration of his bodily strengths and skills; second, the recultivation of human companionships; and third, the reinvocation of his transcendent beliefs and protective gods. Can we as merely mortal physicians do more?

*My secretary first rendered my dictation as "outcasts."

*As a final whimsy, equally susceptible of proof, my secretary first typed "comic."

STUDIES WITH A SOY-DERIVED PHOSPHATIDE IN CLINICAL HYPERCHOLESTEROL- EMIA

Oscar Davis, M.D.; Albert Levine, M.D.; Milton Bergal, M.D.; Noah Sloan, M.D.; and Charles Beck, M.D.

THE SAFE CONTROL OF elevated serum cholesterol remains a matter of medical concern in spite of the fact that its precise relationship to the mechanism by which atherosclerotic lesions are produced has not been elucidated.¹ Cholesterol-lowering drugs have been suggested but thus far a bothersome problem has been the occurrence of unwanted side effects.

It is quite generally agreed that the reduction can be safely brought about by modification in the patient's diet even though the procedure may be somewhat tedious. Dietary modifications include management of the diet to reduce the consumption of cholesterol-rich food and the suitable adjustment of the ratio of ingested polyunsaturated to saturated fatty acids.²⁻⁴

The phosphatide⁵ extracted from soybean oil (Table 1) is a rich, non-oily source of polyunsaturated fatty acids. This, plus its known emulsifying effect and stabilizing

properties, and its acceptance as being devoid of toxicological hazards were the chief reasons for testing its possible usefulness in hypercholesterolemia. On the basis of its composition and its long use as a food ingredient it was assumed that soy derived phosphatide may be safely used and that it should be a dietary aid in the control of elevated blood cholesterol levels.

Briefly this is the background against which it was decided to test the effectiveness and utility of phosphatide extracted from soybean oil with respect to elevated serum cholesterol. The polyunsaturated fatty acid component made the assumption plausible but it was further borne in mind that this product might have an effect over and beyond that of its polyunsaturated fatty acid component.

Test Materials and Methods

Soy phosphatide is a naturally occurring food substance—a component of crude soybean oil. This product contains large amounts of lipotropic agents and is known to be a stabilizer and an emulsifier.

The ratio of unsaturated fatty acids to saturated fatty acids in soy phosphatide is 6 to 1. This contrasts with 1.6 to 1 in peanut oil; 2 to 1 in cottonseed oil and 5.3 to 1 in corn oil.

The approximate composition of the soy phosphatide used in this study is indicated in Table 1.

Observations were made on randomized

Chicago.

Chicago Medical School, Cook County, Mt. Sinai and Edgewater Hospitals.

Methodist and Mercy Hospitals, Gary, Indiana.

Medical Director, All State Life Insurance Co.

Stritch School of Medicine, Loyola University, Jackson Park Hospital, Chicago.

TABLE 1

TWENTY-FIVE GRAMS OF SOY PHOSPHATIDE CONTAINS THE FOLLOWING:		
Linoleic Acid	9.5	gm.
Linolenic Acid	0.5	gm.
Oleic Acid	5.0	gm.
Palmitic Acid	1.5	gm.
Stearic Acid	0.75	gm.
Glycerine	2.25	gm.
Moisture	0.25	gm.
Protein Material	0.075	gm.
Miscellaneous Carbohydrates, Sterols, Nitrogen, etc.	3.0	gm.
Choline	750.	mg.
Inositol	750.	mg.
Phosphorous	675.	mg.

groups of patients from three communities in the Chicago area. The largest unit, consisting of 225 patients was from an upper middle class, culturally mobile group in suburban Chicago. Included were merchants, professional men, white collar workers and their families. Approximately fifty per cent were Jewish. The next unit consisted of employed Negroes and Latin Americans. This group ingested, characteristically, a high carbohydrate diet. The third unit was a mixed group and included both executives and laboring men with widely varying cultural, dietary and ethnic backgrounds. Together, the second and third groups consisted of 137 patients.

No attempt was made to control serum cholesterol levels by dietary means other than by the use of soy phosphatide. Patients presented a great variety of problems, including diabetes and hypertension. Medications were used where indicated and as indicated but no known cholesterol lowering agents were used. All patients were adult and were approximately equally divided as to sex.

Soy phosphatide was administered in granular form in doses of one tablespoonful each, three times daily, or approximately 25 gm. per day.

Cholesterol determinations were made according to the Lieberman Burchard technique by each of three laboratories. In order to minimize differences between laboratories, all tests on each individual pa-

tient were done by the same laboratory.

In order to establish a basal level of serum cholesterol, three determinations were scheduled before soy phosphatide was started. The average of the readings was assumed to be the basal cholesterol level at the time.

After determining the average of the "pre-treatment" cholesterol levels, the daily administration of soy phosphatide was started. Serum cholesterol determinations were scheduled at 6, 12, and 18 weeks of treatment and were carried out on schedule, plus or minus 5 days. It was not possible to follow through to the end with all patients. This is indicated in the accompanying table which shows that 362 patients were on the study at the beginning. It shows also that a lesser number presented themselves for the specified intervals thereafter. However, the number of patients from whom serum samples were drawn are recorded.

After the treatment period had been completed and observations made on serum cholesterol levels, the soy phosphatide was discontinued. Serum levels were taken on 62 patients after a six weeks period without phosphatide. Phosphatide was then started again at the previous level. After six subsequent weeks of treatment serum samples were again taken and recorded.

Results

Averages of serum cholesterol levels before therapy and at specified intervals after therapy had been instituted are recorded in Table 2. Average serum cholesterol levels were established before treatment started on 362 patients. Of these patients, 264 returned for examination and cholesterol determination at the end of the first six weeks. At that time their average serum cholesterol level was 255.9 mg. as compared with a pre-treatment level of 291.7 mg. This difference is statistically significant on the basis of our calculations.

Twelve weeks after treatment had been started 336 patients returned for serum cholesterol determinations and the average of their cholesterol levels was 255.9 mg. which indicated that the average cholesterol

TABLE 2

AVERAGES OF SERUM CHOLESTEROL LEVELS BEFORE AND AFTER THERAPY IN TERMS OF NUMBER OF PATIENTS OBSERVED AND THE CHOLESTEROL LEVELS IN MILLIGRAMS PER CENT OF CHOLESTEROL.

	Before	After			After Stop	After Resume
		6 weeks	12 weeks	18 weeks	6 weeks	6 weeks
Number of patients observed	362	264	336	192	62	111
Average serum-cholesterol levels in mg. %	291.7	256.7	255.9	243.8	277.8	260.2

level was continuing to remain reduced.

At eighteen weeks of therapy 192 patients returned. The average of their serum cholesterol levels remained close to the averages at 6 and 12 weeks.

After eighteen weeks, phosphatide treatment was discontinued and after six weeks without phosphatide 62 patients returned for examination and a serum cholesterol determination. Their average was 277.8 mg. which was midway between the average pretreatment level and the levels reached during the treatment period.

Following this, phosphatide therapy was reinstituted and after six weeks of treatment serum cholesterol determinations were made on 111 patients. Their average serum cholesterol level was 260.2 mg.

Discussion

Any attempt to evaluate data must include consideration of factors involved in its collection. These factors include (1) irregularity of patients' diets, (2) the encroachment of clinical disease, e.g., hypertension, diabetes, etc., (3) the role of drugs used in the management of clinical disease not known to be directly involved with and determination of cholesterol level, and (4) the lack of exactness of tablespoon doses administered by the patient. The majority of the patients ingested diets high in cholesterol—a factor which may be presumed to tend to increase serum cholesterol levels rather than lower them. The direction and significance of other possible influences is difficult to assess. In any event, the tendency for serum cholesterol to diminish concurrently with the administration of soy phosphatide seems apparent. A

degree of further confirmation is supplied by the evidence of a rise after removal of soy phosphatide and a subsequent tendency to fall after it was again administered.

Aside from the complaint from a few patients about its taste, the compound provides enough consistent lowering effect to recommend it for further study as a safe cholesterol lowering agent without untoward side effects.

Summary

1) 362 hypercholesterolemic patients from widely varying ethnic, cultural, economic and dietary backgrounds were observed in three independent clinical investigations. Studied, was the influence of the daily use of 25 grams of a soy derived phosphatide known to be rich in linoleic acid.

3) A statistically significant lowering of the blood cholesterol level supervened following the administration of soy phosphatide at a level of 25 grams daily.

3) Soy phosphatide may be safely used in the dietary management of hypercholesteremia.

4) Further studies may be desirable to evaluate its usefulness more precisely.

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**SPECIAL MEDICO-LEGAL
REPORT**

**BATTERED CHILD
LAW
TAKES EFFECT
JULY 1**

The new Illinois "battered child" law, requiring physicians and hospitals to report suspected cases of child abuse and serious neglect to the Department of Children and Family Services, takes effect on July 1. It gives physicians maximum legal protection.

Dr. Donald Brieland, director of the department, said his office is now preparing a brochure for mailing to all Illinois physicians. It will explain the intent of the law, the simple reporting procedures involved, and the services the department will provide to assure child protection and family rehabilitation, if possible.

Dr. Brieland said figures provided by hospital officials indicate that there may be 200 or more cases reported in Illinois during the next year.

The law states that "anyone participating in the making of a report pursuant to this Act or participating in a judicial proceeding resulting therefrom *prima facie* shall be presumed to be acting in good faith and in so doing shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed." It holds further that "the physician-patient privilege shall not be a ground for excluding evidence regarding a child's abuse, neglect or injury, or the cause thereof" in any resulting court case.

The Act requires that the report "shall be made immediately by telephone or in person to the nearest office of the Department of Children and Family Services and shall *also* be made in writing deposited in the U.S. mail, postage prepaid, within 24

hours of the examination of the child."

"Such reports may in addition be made to the local law enforcement agency in the same manner. In the event a report is made to the local law enforcement agency, the reporter shall so inform the Department."

The law, which defines a child as any person under the age of 16 years, received broad support from groups and individuals within the medical profession. The original bill was drafted by a committee of the Illinois Commission on Children whose chairman was Dr. Ralph Kunstadter, Chicago physician. Also serving on the committee were Dr. Rowine Brown, Cook County Hospital; Miss Mary Jean Clark, Children's Memorial Hospital, Chicago; Dr. Edward Lis, director of the University of Illinois Division of Services for Crippled Children; Dr. Daniel Pachman, Chicago; Dr. W. W. Fullerton, Sparta; David Kinzer, executive secretary of the Illinois Hospital Association; as well as other persons representing the fields of law, government, education, social work and religion.

When signing the bill on March 31, Governor Kerner issued a statement which read in part:

"... child abuse is a serious problem, and there are indications that it has become more acute in the last decade. This new law will not prevent the tragedy of a single violent outburst that may result in the death of a child. However, it should prevent much of the mental and physical damage to children which is the cumulative effect of beatings, other severe punishment, or malnutrition. In this respect, because

the new law hinges on the professional judgment of physicians and other practitioners, it will only be as good as their willingness to use it."

The law states that reports by physicians and hospitals shall include the names and addresses of the child and his parents or other persons having his custody, the child's age, the nature of the child's condition including any evidence of previous injuries or disabilities, and any other information that might be helpful in establishing the cause of the physical abuse or neglect and the identity of the perpetrator.

Dr. Brieland, whose department shoulders the major administrative role of the new law, says his staff will focus on family rehabilitation rather than parental punishment. Caseworkers will furnish protective service to see that no further abuse is inflicted on the child, but emphasis will also be placed on determining what led to the abuse or neglect. Counseling will be given to stabilize the family. If removal of the child is necessary, the Department may petition the court to assume custody and place the child in one of its own institutions or some other child care facility.

The Department will also maintain a central registry of reported child abuse cases to assist casework staff, other agencies and persons.

The Department has eight regional and fifteen branch offices located throughout the state. An up-to-date listing of offices, addresses, and telephone numbers follows.

Aurora, 411 West Galena Boulevard, 896-0881, Area Code 312

Benton, John Green Building, P. O. Box 176, 438-2921, Area Code 618
Bloomington, 526 North Main Street, 967-9079, Area Code 309
Carbondale, #9, 1202 West Main Street, 457-4151, Area Code 618
Carlinville, 494½ West Side Square, 854-3279, Area Code 217
Champaign, 44 Main Street, 356-2583, Area Code 217
Chicago, 160 North LaSalle Street, 346-2000, Area Code 312
Decatur, 125 North Franklin, 429-4425, Area Code 217
East St. Louis, 435 Missouri Avenue, 875-4100, Area Code 618
Galesburg, 121 South Prairie, 342-3154, Area Code 309
Harrisburg, 10 South Vine, 253-7240, Area Code 618
Joliet, 57 West Jefferson, 727-4835, Area Code 815
Murphysboro, Courthouse, 687-1404, Area Code 618
Olney, 115 South Fair Street, 393-2979, Area Code 618
Ottawa, 628-30 Columbus Street, 433-4371, Area Code 815
Peoria, 414 Hamilton Boulevard, 676-7601, Area Code 309
Princeton, 22 East Marion Street, 51058, Area Code 815
Quincy, 410 North Ninth Street, 223-7187, Area Code 217
Rockford, 428 Seventh Street, 965-8741, Area Code 815
Rock Island, 211-18th Street, 788-3468, Area Code 309
Salem, 111 South Maple, 548-1692, Area Code 618
Springfield, 528 South Fifth Street, 525-6513, Area Code 217
Waukegan, 4 South Genesee Street, 244-0595, Area Code 312

Introduction

Rocky Mountain Spotted Fever is an acute specific and infectious endangiitis chiefly of the peripheral blood vessels in which the etiologic agent is *Rickettsia rickettsii*. The first reports of Rocky Mountain Spotted Fever occurred during the final decade of the 19th Century in Idaho and Montana.^{1, 2} However the disease has been reported in all of the continental United States except Maine and Vermont. There are about 300 cases reported annually in the United States, and Smadel reported the attack rate in Illinois as 1-10 per million population.³

Case Report

The patient (W. F. T.) was a young construction laborer, who was admitted to the Carle Hospital on June 15, 1964. On June 3, 1964 he had

developed malaise, fever and a headache which had persisted. On June 5th he had received ampicillin and trisulfapyrimidines from his local physician: these medications were without benefit. On June 7th he developed a skin eruption, which started on the feet and hands and then spread to the legs, arms and trunk. He also developed migratory polyarthralgias.

The patient lived in rural Charleston, Illinois and had been building a home in an area infested with wood ticks. He stated that he had had tick bites, but that none of the ticks had sunk into his skin to remain attached.

He was a 20 year old, thin, well developed white male who appeared acutely ill. The blood pressure was 122 mm. Hg. systolic and 78 mm. Hg. diastolic. The temperature was 102° F. (oral). The physical examination of the heart, lungs, abdomen, genitalia, rectum and prostate gland was within normal limits. There was a generalized deep red macular rash: the rash had many more lesions upon the feet, legs, and arms than upon the trunk.

The chest x-ray was negative for active pathology. The 12 lead electrocardiogram was normal. The hemoglobin was 12.5 gms/100 ml., the erythrocyte count was 4,700,000/cu. mm., and the leucocytes numbered 14,100/cu. mm. The differential white count was 77% neutrophils, 11% lymphocytes, 10% monocytes, 1% myelocytes and 1% juvenile cells. The sedimentation rate was 43 mm. at the end of 45 minutes (Westergren Method). The anti-streptolysin O titer was 125 Todd units, the Kahn test was non-reactive, and the routine urinalysis was negative.

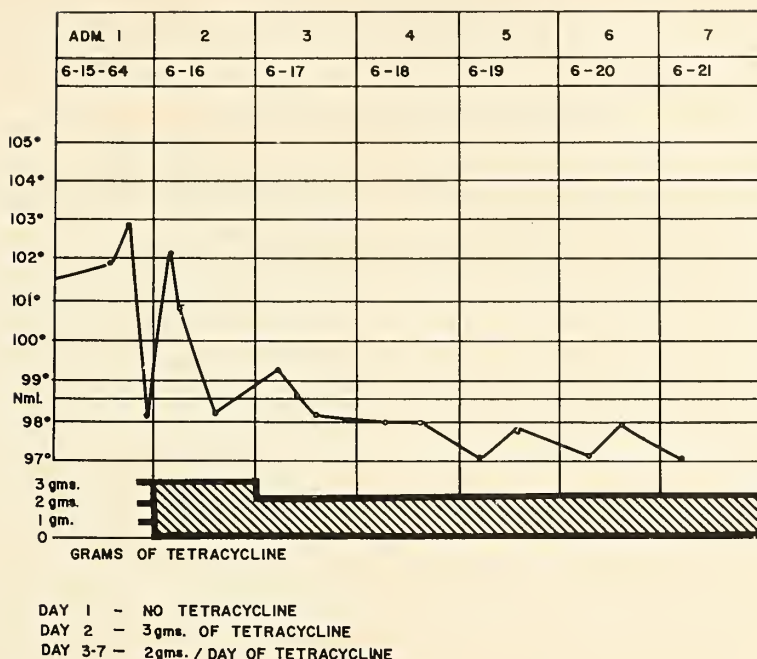
Two separate blood cultures were negative for bacterial growth at the end of 48 hours and were also negative at 2 weeks. The agglutinations for Typhoid O, Typhoid H, Paratyphoid A, Paratyphoid B, and Brucella AB were negative. However, the agglutinations for *Proteus* OX19 were consistently positive as were the complement fixation tests for Rocky Mountain Spotted Fever. The *Proteus* OX19 agglutination was as high as 1:10240, and the Rocky Mountain Spotted Fever complement fixation test was positive 1:512.

The patient was started upon tetracycline therapy on June 16, 1964. He had been spiking temperature of 102°-103° F. (oral) in the afternoons

ROCKY MOUNTAIN SPOTTED FEVER: A SAGA OF THE LAND OF LINCOLN

Earl Richard Ensrud, M.D./urbana

FIG. 1 W.F.D - ROCKY MOUNTAIN SPOTTED FEVER



prior to the initiation of treatment. As shown in Fig. 1, 24 hours after starting tetracycline the patient was afebrile, and he was discharged asymptomatic on June 21, 1964, the 7th hospital day.

He was seen as an outpatient on July 11, 1964, there had been no exacerbation of the disease, and he was feeling well.

Discussion

The etiologic agent of Rocky Mountain Spotted Fever is the rickettsial microorganism, *Rickettsia rickettsii*, which is one micron in length and 0.2-0.3 microns in width. It stains purple with the Giemsa stain. The organisms grow in the nucleus as well as the cytoplasm of infected cells of ticks, mammals and embryonated eggs. Man is only occasionally involved in the disease by the bite of an infected tick (*Dermacentor andersoni* in the Western states and *Dermacentor variabilis* in the Eastern states). A reservoir of the organism is maintained in nature in arthropods and animals.

Infection is accidentally acquired in the human from an infected tick by a bite usually lasting several hours. However infection may also be acquired through skin abrasions contaminated with infected tick feces or tissue juices. The incubation pe-

riod after exposure is 3-12 days, at which time there is the sudden onset of headaches, chills and fever to 103°-104° F. Arthralgias are fairly common with the pyrexia. The fever in untreated cases will last 15-20 days. The characteristic exanthem occurs about the 4th day after the onset of the disease. The rash is macular with the initial and greatest number of lesions on the extremities. The lesions which are 2-6 mm. in diameter also occur later and in lesser numbers on the trunk. The lesions not uncommonly coalesce into ecchymotic areas. Brownish pigment discolorations persist for several weeks during convalescence.

The leucocyte count in Rocky Mountain Spotted Fever is usually normal although leucopenia or leucocytosis are occasionally observed. There is often also a transient albuminuria. The Weil Felix Test (*Proteus* OX19) and the Rocky Mountain Spotted Fever complement fixation test become positive during the 2nd-3rd week of the disease.^{4,5}

The course of the disease prior to the availability of specific antibiotic therapy was 2-3 weeks and the mortality rate was

20%. With specific antibiotic therapy the severity of the disease is lessened and the mortality is decreased to 7%. Tetracycline and chloramphenicol are the antibiotics, which are specific against Rocky Mountain Spotted Fever. The suggested dosage for tetracycline is the administration of 3-4 gms. within the first 8 hours and 500 mgs. every 6 hours thereafter until the temperature has been normal for 24 hours. The initial dose suggested for chloramphenicol is 50 mgs./kilogram of body weight followed by 500 mgs. every 4 hours until the temperature has been normal for 24 hours.^{6,7}

Summary

An account has been given of a case of Rocky Mountain Spotted Fever contracted in East Central Illinois where its occurrence is uncommon. The patient developed the typical clinical features, the specific

agglutination tests were markedly positive, and there was a rapid recovery after the initiation of tetracycline therapy. The clinical and laboratory features of Rocky Mountain Spotted Fever were reviewed and discussed.

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THE VIEW BOX

Director, Diagnostic Radiology
Cook County Hospital



Fig. 1

This 35-year-old male entered the hospital because of sudden acute pain in the right side of his chest and marked shortness of breath. (Fig. 1)

He was treated for spontaneous pneumothorax by needle drainage, with about 75% re-expansion of the right lung. He signed himself out of the hospital against the resident's advice. He returned the next day acutely short of breath and stated that he had been hit in the chest during a fight.

What is your diagnosis?

- 1) Pneumopericardium
- 2) Pneumomediastinum
- 3) Emphysematous bullae

(Answer on next page)

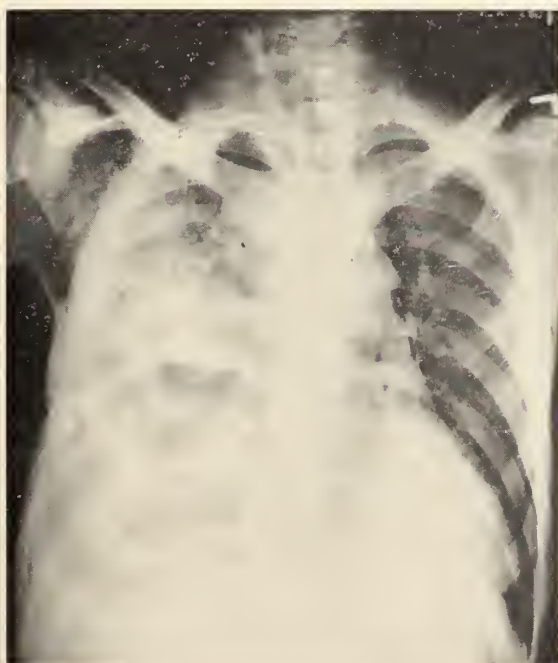


Fig. 2



Fig. 3

THE VIEW BOX---DIAGNOSIS AND DISCUSSION

(continued from preceding page)

Diagnosis: The patient now had an acute pneumomediastinum.

The diagnosis of pneumomediastinum on X-ray is suggested by the following findings on the PA film (Fig. 2). The bilateral mediastinal pleural air column outlines the medial borders of the lungs and the lateral margins of the heart and great vessels. The upper thoracic column is better delineated. In an infant the thymic shadow will be elevated upward (spinnaker sail sign). The lateral film (Fig. 3) reveals a large collec-

tion of air in the anterior mediastinum with marked posterior displacement of the mediastinal structures. As demonstrated on the lateral examination, the loculated air in the anterior mediastinum is located in a high position.

A needle was inserted into the anterior mediastinum and underwater drainage was instituted which relieved the acute dyspnea and allowed the heart and mediastinal structures to return to their normal position.

STOMACH CANCER

In the past 5 years, we treated 6 young patients of stomach cancer, and their data were reported with reference to pertinent literature.

As to sex distribution, one was male, and the other 5 were female; the ages ranged 17-29 years, 2 being in the teens, and 4 in the twenties.

Out of 6 cases, only one was shown on the first examination to have digestive symptoms, and in all the other 5, these were concealed by complications. Case 1 was misdiagnosed as mere stomach ulcer on account of the young age of 17 years despite complaint of digestive symptoms, case 2 as pulmonary tuberculosis owing to lung metastasis, case 3 as hyperemesis gravidarum owing to pregnancy, case 4 as mere acute hepatitis owing to jaundice derived from liver metastasis, and cases 5 and 6 as leukemia owing to bone metastasis. As the consequence, all had already lost chance of radical operation when they visited our clinic. The whole course from the onset of clinical symptoms to death ranged 2 months-2 years 8 months with average of 11.6 months.

Histological examination in autopsy discovered carcinoma simplex in 3 cases, and carcinoma simplex mucocellulare in the other 3. According to the Borrmann's classification, 3 were type III, and 3 of type IV.

It was noteworthy that all of our cases were positive in the Shichijo's reaction. "*The Gunma Journal of Medical Sciences*," Vol. XIII, No. 1, March, 1964.

PRELIMINARY STUDY OF ILLINOIS DROWNINGS

*Edward Press, M.D., James Walker, and
Isabelle Crawford/chicago*

EACH YEAR ABOUT 6,000 PERSONS in the United States die by drowning. Recently there has been a marked increase in such aquatic sports as boating and scuba diving. In addition, there has been a substantial building boom for both public and private swimming pools. In view of these factors, associated with the greater amount of leisure time available to so many of our citizens, the exposure to drowning possibilities is bound to increase. It is thus likely that unless our preventive efforts are intensified and sharpened, the number of drownings will increase substantially.

Many of the epidemiologic principles worked out by the public health and medical specialists against such diseases as plague, malaria, typhus fever, etc., can be turned to effective use in combatting such non-communicable disorders as cancer, heart disease, and accidents. With this goal of the epidemiologic approach to accidental drownings in mind, and in view of the lack of detailed data from published national and state vital statistics resources on the specific circumstances and factors in drowning, the Illinois Department of Public Health conducted a preliminary study of drownings that occurred during the summer of 1964.

As an introduction to the problem in Illinois, a review was made of all death

certificates reporting drowning as the cause of death filed in Illinois from 1949 to 1963 inclusive. This review was limited to factors available from the death certificate. It included primarily the age of the persons involved, whether or not the drowning occurred in association with a boating activity, and the location of the drowning.

The results revealed that the number of deaths per calendar year fluctuated from a low of 265 in 1963 to a high of 376 in 1952. The average number of annual deaths during this 15 year period was 305. For 1963, which was the latest period for which the figures were available for an entire calendar year, 51.3% of the drownings were under 20 years of age; 24.9% between 20 and 44 years; 16.6% between 45 and 64; and 7.2% 65 years of age or older.

During this same year, i.e. 1963, 41 of the 265 drownings occurred from small boats, and 2 occurred in other larger boats, making a total of 43, or 16% of all drownings that year associated with boating accidents. Only 10 of the total drownings in 1963 occurred at home, and over 154 in public places.

In studying the various factors involved in drowning, emphasis was placed on those circumstances which might be amenable to preventive or remedial action. Considered were such items as whether the drowning site was a public or private swimming pool, river, lake, or quarry; the presence or absence of injuries, such as striking one's head in diving; the type of activity—fishing, boating, sailing, swimming; whether or not the individual was a good swimmer or

Medical Assistant to the Director.

Statistician, Bureau of Vital Statistics.

Supervisor Data Processing Section, Bureau of Vital Statistics.

FIGURE 1
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DROWNING STUDY

1. NAME OF DECEASED: 1A LAST 1B FIRST		2. DATE OF DEATH: MONTH DAY YEAR		3. AGE:	4. SEX: 1 <input type="checkbox"/> MALE 2 <input type="checkbox"/> FEMALE
RESIDENCE OF DECEDENT: 5A. STREET ADDRESS 5B. TOWN, VILLAGE COUNTY					5. CODE:

6. NAME AND LOCATION OF DROWNING SITE:

1 <input type="checkbox"/> _____ River	5 <input type="checkbox"/> _____ Public Swimming Pool, Life Guard Present
2 <input type="checkbox"/> _____ Quarry	6 <input type="checkbox"/> _____ Public Swimming Pool, No Life Guard Present
3 <input type="checkbox"/> _____ Lake	7 <input type="checkbox"/> _____ Private Swimming Pool, Life Guard Present
4 <input type="checkbox"/> _____ Farm Pond	8 <input type="checkbox"/> _____ Private Swimming Pool, No Life Guard Present

7. ANY HISTORY OF INJURY ASSOCIATED WITH THE DROWNING:

1 ☐ YES (Specify) _____

2 ☐ NO

8a. OTHERS DROWNED IN SAME ACCIDENT:	8b. ANYONE PRESENT AT TIME OF DROWNING:
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 3 <input type="checkbox"/> DO NOT KNOW	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 3 <input type="checkbox"/> DO NOT KNOW

9. AT TIME OF DROWNING, DECEASED WAS:

1 ☐ Swimming 2 ☐ Fishing 3 ☐ Boating 4 ☐ Sailing 5 ☐ Playing 6 ☐ Other _____ (specify)

10. TYPE OF SWIMMER:	11. WATER VERY COLD:
1 <input type="checkbox"/> Good 2 <input type="checkbox"/> Average 3 <input type="checkbox"/> Unable to swim 4 <input type="checkbox"/> Do not know	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Do not know

12a. DRINKING ALCOHOLIC BEVERAGES:	12b. MEAL WITHIN AN HOUR OF DROWNING:
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 3 <input type="checkbox"/> DO NOT KNOW	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 3 <input type="checkbox"/> DO NOT KNOW

13a. COMPANIONS OR BYSTANDERS ATTEMPT TO RESCUE VICTIM:	13b. VICTIM DROWNED WHILE TRYING TO SAVE OTHERS:
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 3 <input type="checkbox"/> DO NOT KNOW	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 3 <input type="checkbox"/> DO NOT KNOW

14a. USE OF ARTIFICIAL RESPIRATION:	14b. TYPE OF ARTIFICIAL RESPIRATION USED:
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Do not know	1 <input type="checkbox"/> Mouth to Mouth 3 <input type="checkbox"/> Arm Lift 5 <input type="checkbox"/> Other
	2 <input type="checkbox"/> Prone Pressure 4 <input type="checkbox"/> Pulmotor _____ specify

15. LIFE PRESERVERS ON VICTIM OR COMPANIONS IF BOATING OR SAILING ACCIDENT:

1 ☐ YES 2 ☐ NO 3 ☐ DO NOT KNOW

16. DESCRIBE IN YOUR OWN WORDS, HOW DROWNING OCCURRED (use reverse side if necessary):

17a. REPORT PREPARED BY: _____ Name of Informant	17b. DATE OF REPORT: _____ Month Day Year
---	--

17c. ADDRESS OF INFORMANT: _____
Street and Number City, Town, Village

MAIL COMPLETED QUESTIONNAIRE TO: ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ROOM 500 STATE OFFICE BUILDING
SPRINGFIELD, ILLINOIS 62706

did not know how to swim; whether he had eaten within an hour of the drowning accident; whether he had been drinking alcohol; whether or not artificial respiration was attempted and the type used, etc. Figure 1 shows the form that was mailed to the coroners of all counties in Illinois from which drownings were reported during June, July, and August of 1964.

Results

Questionnaires were sent out on all of the 132 drownings for which final Certificates had been received by the State Registrar of Vital Statistics during these three months of 1964; 130 were returned in time for inclusion in this summary. The 130 returned represented 98.5% of those to whom a questionnaire had been mailed.*

As anticipated, one of the commonest drowning sites, possibly because of the significantly increased exposure with literally millions of man hours at risk, was Lake Michigan and other lakes throughout the State. It was not surprising to see that 57 of the 130 drownings occurred in lakes. The next leading sites were rivers, with quarries, farm ponds, and private swimming pools without life guards following in that order. The results also revealed the increased risk of drowning for teen-aged boys in the lake.

Analysis of the activity at the time of the drowning by sex and age, showed that fishing and sailing appeared to be among the safest activities. Although there was only one death from a sailing accident it must be remembered that the number of those exposed to sailing is substantially smaller than those involved in swimming, fishing, and boating. Of the boating fatali-

ties, 7 of the 12 were among males from 20 to 64 years of age.

The ability to swim has long been regarded as a desirable skill, both from the standpoint of being a healthy, enjoyable recreational activity, as well as an added safeguard against drowning from accidents occurring while boating or fishing. Thus it was natural to include the ability to swim in the analysis of the factors involved. In interpreting this analysis, it must be remembered that the distinction between a "good" and "average" swimmer for the purpose of this study was made by the coroner on the basis of information obtained from witnesses, or friends, of the deceased; thus the distinction between a good and average swimmer was more subjective than objective. Nevertheless, fully 35% of the 130 persons that drowned were classed as good or average swimmers. In further evaluating this factor, such elements as over-confidence, "showing off," as well as fool-hardiness, must be taken into consideration. For example, 27 of the 46 deaths among good and average swimmers were those that occurred to boys between 5 and 19 years of age, and a substantial percentage of these were in individuals attempting to swim farther than they actually could. For example, the description of the drowning for one 19 year old who was considered an average swimmer was as follows:

"This boy was swimming in lake and swam out too far and got tired and could not make it back. He was clowning just before he howled for help, and maybe companions thought he was still clowning."

Another description of a 17 year old boy drowning in the Mississippi River was:

"The deceased was one of 16 on a pontoon boat. Motor didn't start. He and another passenger jumped overboard to stop boat from getting into strong current. Where he jumped in, it was over his head and in the strong current."

Again, another 17 year old boy, who was considered one of the best swimmers in the area, drowned in the following manner:

"Victim was diving through a large coal

*Seven tables giving the details of the variables studied by age and sex have been compiled. Because of space limitations the tables have not been published with this article. However, a limited quantity of each of the seven tables is available for free distribution to those with special interest. Requests for these should be addressed to the Data Processing Section, Bureau of Vital Statistics, Illinois Department of Public Health, Springfield, Illinois 62706.

mining truck inner tube from 10-foot diving board. Apparently, an error in judgment caused him to strike the tube with his chest, knocking all the air from his lungs; as he gasped for air, he filled his lungs with water and sank to the bottom. Autopsy was performed, as he was considered one of the best swimmers in the area."

A much briefer "epitaph" for an 18 year old person who was considered an average swimmer and in which companions attempted unsuccessfully to rescue him was:

"Swimmer became exhausted."

And again, a 15 year old youngster considered an average swimmer swimming in a farm pond:

"Boy tried to swim across pond which was about 40 yards long, got about half way and shouted for help. Another boy grabbed him but could not hold. Sank in about 10 feet of water."

The question of the role of alcohol ingestion in either impairing one's judgment as to the ability to swim, or in reducing resistance to cold water, or making one more likely to boating accidents is a factor that it was felt should be explored. An analysis of the use of alcohol just prior to the drowning showed that this was noted in 13% of the deaths. Most of these were in persons over 20 years of age, and the men outnumbered the women 15 to 2. In many instances, it was not clear whether or not the use of alcohol was, in fact, a predisposing element, or whether it reflected the current, coincidental cultural and social activities of persons involved in water sports or swimming. However, in a few instances, it clearly played a role; for example, one 34 year old male who was drinking heavily and had a blood alcohol level of .248% jumped from the center of a bridge over a lake in order to win a bet. In another instance, a 28 year old white male in the presence of companions (this man, according to the coroner's statement was "under the influence of alcohol") jumped into Lake Michigan fully clothed.

In a third instance, a 23 year old male who had been drinking alcohol, again in the presence of companions, met his death by:

"Horse play on boat — fell overboard. Swam about for a while; then distressed. Others attempted to rescue him but lost him (at night)."

The effect of "cramps" and of eating a large meal just prior to going swimming has long been considered, in a sort of vague fashion, as a factor contributing to otherwise unexplained drownings. There are ample instances of bulging tetanic contractions of muscle groups, such as the calf muscles in the leg, or other instances in which there is specific and painful contractions of voluntary muscle groups, often relieved by pressure and rubbing. However, so-called abdominal "cramps" are much less clear cut and specific. They have been attributed to a variety of factors such as sudden heart attacks, strokes, or a generalized hypersensitivity to cold with the release of histamine-like substances.*

Because of these possibilities, items dealing with whether or not the water was very cold and whether or not the individual had had a meal within an hour of the drowning were included.

For only 8 of the 130 persons drowned was it known that they had had a meal within an hour of drowning. Of these 3 were considered good or average swimmers. In 64, or 49% of the cases, it was not known whether or not they had eaten, and for 58 of the victims, it had been over an hour since their last meal.

In only 19 instances was the water reported as cold, and in almost half (i.e. 7) of these cases the deceased was considered a good or average swimmer and the temperature of the water may have been a contributing factor.

The admonition to use life preservers while boating or sailing is a precaution frequently recommended by many recreational and safety leaders. Accordingly, an attempt was made to see whether or not any of the drownings associated with boating and sailing occurred among persons that used life preservers. There was only one

*Sigal, C., and Mitchell, J. C., "Essential Cold Urticaria, a Potential Cause of Death While Swimming," Canadian Medical Association Journal, Vol. 91, pages 609-611 (8-12-64).

such instance and it appears to be an excellent one for substantiating the precaution.

"A 38 year old man was sailing with companions in a small boat on Lake Michigan; his companions were wearing life preservers but the victim was not. When the boat capsized the victim drowned though his companions attempted unsuccessfully to save him. It was not known whether the victim could swim."

Discussion

Efforts to prevent drowning, like efforts to reduce disability or disease from any cause, are most effective when they can be aimed at some of the tangible, specific factors involved. Simple statements like "be careful when you go swimming," or "drive carefully when in a power boat" usually mean little or nothing to the potential drowning victims. On the other hand, if it can be shown that specific factors such as swimming in excessively cold water; swimming at night; swimming in abandoned quarries and in unsupervised beaches, ponds, and rivers are factors, then special efforts can be made to neutralize or counter these factors. Such efforts might be directed at providing more adequate public bathing facilities, of stressing the avoidance of factors, such as night-time swimming, swimming after drinking, over-confidence in one's ability to swim distances, or of the need for fences around private pools, etc. They should be directly related to the major drowning circumstances.

It must be remembered that a single

study of only one state, such as this one, particularly during a limited period of time, one can not usually obtain statistically significant results. Such a study, to have its optimal effect, should extend over a full year, as many of the drownings (about 40% in Illinois) occurred during the other 9 months of the year, and these may well be of a significantly different nature. Also, the type of drowning accident that occurs among states that border on the ocean or those in the southern part of the United States could be substantially different from those in Illinois. Accordingly, it is felt that a full year's study, one that would preferably include several different states scattered throughout the United States, would be desirable. In line with this, efforts are currently under consideration to launch such a study.

Summary

A study of 130 drownings reported to the Registrar of Vital Statistics of the State of Illinois during the months of June, July, and August, 1964, was made. The drowning deaths were analyzed for several different variables including age, sex, activity at time of drowning, site of drowning, swimming ability, temperature of water, food or alcohol ingestion prior to drowning, injuries associated with drowning, effectiveness of rescue attempts and of artificial respiration, etc.

It was devised as a preliminary study in an effort to determine the feasibility and technique of making a more extended and detailed study. The findings have been distributed and efforts to launch the more extended study are under way.

EDITORIALS

MEDICAL CARE FOR THE GREAT SOCIETY

The 35 recommendations of the President's Commission on Heart Disease, Cancer, and Stroke are beyond the scope of the average physician. Many of those who heard Dr. Michael E. De Bakey discuss the President's program sat in awe as the solution to the health needs of the people of a Great Society were described. It was too bold, too magnificent, and beyond the comprehension of even the most sophisticated physician. This was difficult to believe because there are many things that money cannot buy regardless of the affluence of those enlightened scientific and political leaders.

The President's health program calls for an all-out attack on cancer, heart disease and strokes utilizing regional treatment and

research centers. It includes grants to medical schools, loan guarantee programs to encourage group practice, increased health research projects and grants, better health facilities for children, increased mental retardation projects, mental health centers, hospital care and treatment for the elderly, and extension of library service. The cost is beyond comprehension and the same can be said for the acquisition of skilled manpower.

The plan is within the realm of possibility but so enormous that most of us may not live to see it implemented. No one wants to stand in the way of progress but haste often leads to waste when plundering into areas that require considerable study and action.

T. R. Van Dellen, M. D.

LOW CARBOHYDRATE DIETS

The low carbohydrate (60 gm.) reducing diet is the latest fad. The dieter can forget proteins, fats, alcohol and calories according to the promoters of the plan. We have had no experience with the diet but any reducing program has merit so long as the patient eats less.

The physiological basis for this type of diet is sound. When food is ingested in excess of the needs of the body (whether consumed in the form of carbohydrates, proteins, or fats) the equivalent of the excess calories is deposited as fat. Carbohydrates are the principal ready source of fuel for the body. Very little is stored and a fresh daily supply is needed for maximum

efficiency. When carbohydrates are curtailed the body must resort to stored and ingested fats and proteins for energy. This is a wasteful process because energy must also be used for the conversions. This creates some wear and tear on the metabolic machinery but it has the desired results for those wanting to lose their excess blubber.

The wear and tear in these instances is not so serious as it is on those undergoing prolonged starvation under experimental conditions. The carbohydrate stores are used up quickly and the amino acids are used for glycogenesis. This means a greater excretion of nitrogen. Uric acid accumulates in the blood from the destruction of large

numbers of cells. Ketosis may occur when metabolism shifts toward the oxidation of fat.

The 11 obese patients who were starved by Drenick and his colleagues¹ for periods up to 117 days, experienced little discomfort. No immediate serious side effects were noted and those who attained a normal body weight were enthusiastic and delighted with their new figure. All developed hyperuricemia (two had clinical gout) and some noted postural hypotension. Anemia also occurred; avitaminosis was avoided by giving a multi-vitamin pill.

The most surprising observation was the

lack of hunger. This was unusual because the prolonged use of low caloric diets in the treatment of obesity is usually associated with hunger. It also leads to weakness, irritability, depression, and a preoccupation with thoughts of food. Psychology may play a strong role but it is difficult to understand why the severe obese individual is not hungry during a fast but is hungry when consuming a calorically inadequate diet.

T. R. Van Dellen, M.D.

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A POST-LILEYAN VIEW OF ERYTHROBLASTOSIS

Crowds estimated at over one million viewed Virgil Grissom and John Young, our newest outer space heroes. Only a small number of fortunate physicians had the privilege of paying honor to medicine's newest hero of inner space, Dr. A. W. Liley of New Zealand.

Those doctors who were present at the meeting of the Chicago Gynecological Society on March 19, 1965 and at Resurrection Hospital, Chicago, Illinois on March 20, 1965 witnessed a major achievement in medicine.

Doctor Liley presented his work on the predictions of the severity of the involvement of erythroblastosis on the fetus by a spectrophotometric analysis of the amniotic fluid obtained by amniocentesis and his study of the treatment of the erythroblastotic fetus in utero with repeated intra-peritoneal transfusions of blood. He was able to raise the hemoglobin of severely involved fetuses several grams higher than they would have been had the procedure not been carried out. He reported a much lower incidence of still births and a higher survival rate in the severely involved erythroblastotic infants following exchange transfusions after birth.

Doctor Liley reported on 44 successful intra-peritoneal transfusions in 31 cases. Thirteen cases were severely hydropic as

noted on X-ray and died. In 18 cases with no or minimal hydrop 13 successful intra-peritoneal transfusions were reported. These were severely involved cases as determined by spectrophotometric determination. Prior to the intra-peritoneal transfusion Urografin was injected under local anesthesia into the amniotic cavity. This visualizes the position of the placenta and the position of the gastro-enteritis tract after Urografin was ingested by the fetus. One to three intra-peritoneal transfusions of about 100 cc of packed warm group O RH-negative cells were given between 28 and 35 weeks. Over 95% replacement of fetal cells by adult cells resulted from this procedure. Hemoglobins as high as 12.5 grams have been reported at birth in contrast to the hemoglobins of 3 to 6 grams if the procedure is not done.

Doctor Liley has demonstrated the importance of the level of hemoglobin on the survival of the erythroblastotic newborn. It would appear that more attention be paid to maintaining the hemoglobin in severely anemic infants with hemoglobins in the 3 to 6 gram range in cases not having had intra-peritoneal transfusions.

The question of early versus delayed clamping of the cord and the question of the initial withdrawal of blood and the cre-

(continued on next page)

ation of defects of blood at the beginning of an exchange transfusion have to be re-evaluated.

Doctor Liley has broken a barrier in entering the heretofore inviolable area of the living fetus in utero. Perhaps his pioneering efforts will encourage other investigators to find ways to diagnose and treat other diseases of the fetus. Certainly his works

have shown the vital importance of close cooperation of obstetricians and pediatricians in treating the mother and her fetus.

Harvey Kravitz, M.D.

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ALCOHOL AND ACCIDENTS

We hear frequently that alcohol is a major contribution to traffic accidents. The New York experience is typical in that half the drivers (51%) who died within 24 hours of the mishap in 1964 had been intoxicated at the time of the accident. The same applied to 30% of pedestrians over 16 years of age. The percentages are higher when death occurs within 6 rather than 24 hours.

Many policemen believe that arresting the drinking driver is a life saving procedure. The inebriated persons are prevented from killing themselves and others by being stopped before there is an accident.

The role played by the alcoholic in traffic fatalities is difficult to deny. On the other hand it has never been subjected to scientific evaluation. In other words what percentage of drinking drivers never have an accident? What percentage of those under the influence of alcohol on any given night have an accident? Many of these men and women get home safely with the help perhaps of a guiding angel.

Others have ingenious automobiles; they press a push button labeled drunk that takes them straight home. But skill, driving experience, and knowledge of the road must play a role in helping the tipsy driver avoid accidents. In addition, many know how to compensate for the ill effects of alcohol. The lack of these skills may explain why the drinking teenage driver has a high accident rate. In these cases the youngster does not know how to drink or how to drive.

T. R. Van Dellen, M.D.

RUSSIA VISIT REVIEWED

Richard C. Schultz, M.D./des plaines

RECENT CHANGES IN RUSSIAN LEADERSHIP and apparent philosophy of motivation have created new hope among many Americans for improved political relations with the Soviet Union. Since this change, many questions from friends and acquaintances have prompted me to review my observations of that country and its people.

Several years ago, while doing research in Sweden, arrangements were made for me to visit Professor A. A. Vishnevsky at the Vishnevsky Institute in Moscow. In addition to professional interest, I hoped the trip would provide an opportunity to see some of that intriguing country, and possibly provide some basis for insight into Russian motivation.

While it would be impossible to draw any sweeping conclusions from a visit of two weeks, the trip proved a most rewarding experience in many ways. Reviewed now with the clarity of hindsight, it seemed that even at that time there were indications that Russia was nearly ready for this "next step" away from Marxian communism. En route to Moscow, I stopped in Leningrad

Clinical Instructor, University of Illinois College of Medicine, Department of Surgery, Division of Plastic Surgery, Chicago.

Fulbright Scholarship in Plastic Surgery, University of Uppsala, 1960-61.

for a week of sightseeing. The flight from Stockholm was made in an ancient, government owned and operated two-propeller Russian airliner. During the trip, we observed a general untidiness of everything from the interior fittings of the plane to the exterior of our overweight and over-painted, red-haired stewardess. Even the captain, casual in his crumpled uniform and cossack-type hat, presented quite a contrast to the snappy, pressed personnel common to most commercial airlines.

In direct contrast to our airplane were nearly forty large modern Russian jet airliners on the field when we landed in Leningrad. From the field we were taken as a closely supervised group into the side door of a large neo-classic type air terminal and directly to the customs room, which bore the mark of former Victorian elegance in its heavy furniture, potted palms and inlaid floor.

Here we met our first Intourist guide. She was a most attractive girl with trim figure, light hair and fine features. She was anything but our preconceived picture of the short, stocky, blunt-featured Russian prototype. Well-dressed by Russian standards, she too wore a cossack hat, and was heavily perfumed. (Something of Capitalistic tendency.)

On our bus ride down Moscow Avenue to the Astoria Hotel, we were impressed by the size of streets—six or more lanes by our standard of measure. There were few cars on the street, and those we saw were all Russian-made. They appeared in good condition and resembled the U.S. cars of the early 1950's. The drivers generally appeared wild and unpredictable with little regard for other drivers or pedestrians. At

the time of another bus ride on the tour, our driver pulled out to pass a truck and forced an oncoming truck off the highway. He did not pause, or even take much interest in the rear view mirror.

Mass transportation in Leningrad and Moscow was partially provided by large, relatively modern buses. Passengers were supposed to pay on the honor system, but fare boxes appeared to be mostly ignored. In addition, the subway systems in both Leningrad and Moscow are among the most modern, and surely the most beautiful in the world, featuring attractive tile floors and walls with extensive displays of art work. This included sculpture, stained glass art, and elaborate chandeliers incorporated into the architecture.

During these last few days in December, we noted occasional "Christmas trees" being carried home. We learned, however, that the Russians decorate these trees for New Year's celebration, not for Christmas. It is then that their Santa Claus, "Father Frost," delivers his presents to the children.

Since most stores stayed open until 8 p.m. to accommodate the working people (nearly 100% employment, I was told), we spent part of one evening exploring the large local G.U.M. department store. On display was a remarkable variety of consumer goods, including tree ornaments, vacuum cleaners, radios, TV's, phonographs, refrigerators, guns, skis and skates. At that time there were no supply problems, since few Russians had the large sums of money necessary to pay cash for these expensive luxuries. However, I understand that several months after my visit the "Capitalistic trap" of credit buying was introduced in Russia, and production has never again been able to keep up with consumer demands.

The second leg of our journey, the flight to Moscow, was made in one of the large, modern jets we had seen, and it proved to be tastefully furnished and efficiently operated. The passengers were courteously cared for by an attractive stewardess who gave flight explanations in five languages: Russian, German, French, Chinese, and English. It was interesting to note, how-

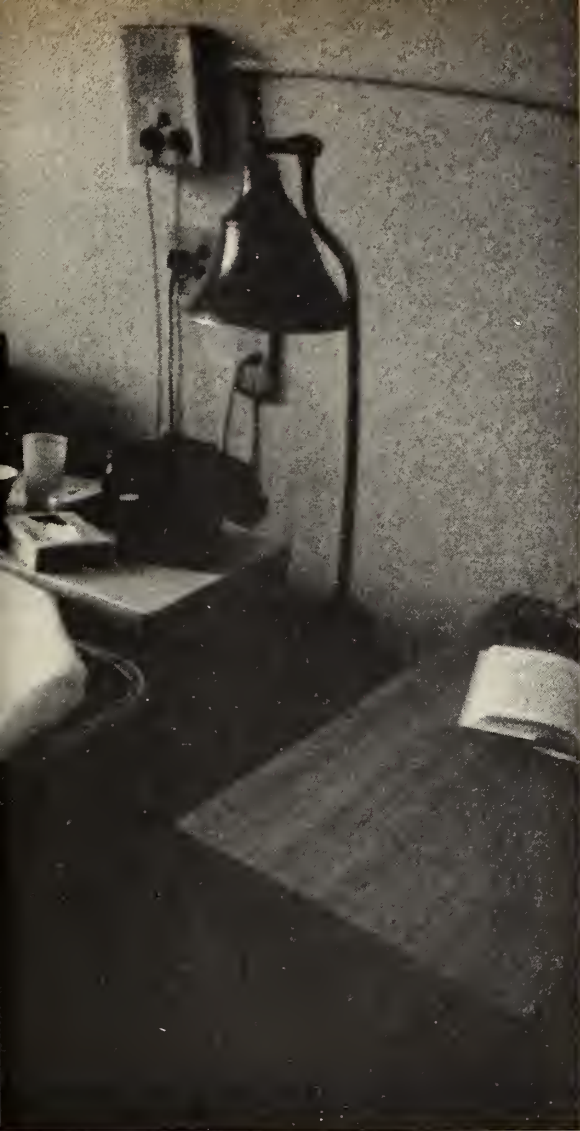
ever, that the scheduling of flights, at least at that time, was taken very casually. It was not uncommon for tourists to be taken to the airport one or two days in succession in clear weather only to be returned to their hotel with instructions as to when to prepare for the next flight. It appeared that scheduled flights often took place at the convenience of the government. This was not the only incidence of this tendency in government-managed enterprises however. Once in Leningrad and again in Moscow, I sat and enjoyed a ballet performance different from the one which was shown on the marquee and for which I had purchased my ticket. This, in no way detracted from the artistic superiority of their ballet, but was certainly at odds with what we are accustomed to in the U.S. theater.

Moscow surprised us by the degree to which it appeared outwardly cosmopolitan and sophisticated. The face of the city itself was much older and more varied than Leningrad, with architecture ranging from old Byzantine Churches to the new buildings of modern Russian simplicity. I was impressed at that time by the number of people on the streets in military uniform, reminiscent of the large cities in the U.S. during World War II.

Here, as elsewhere, we found the Russian people to be warm and friendly. They seemed curious about visitors to their country and eager to ask questions whenever the opportunity presented. These opportunities were encountered much more frequently than anticipated. Everyone with even the smallest smattering of English seemed eager to learn where visitors were from and what it was "really like" outside of Russia. Strangely, it was rarely political ideology they chose to discuss. Almost invariably their questions were of a strictly materialistic nature: How much does a carpenter earn in America? A factory worker? A bus driver? How much did my camera cost? My car? My house? Everywhere the questions were nearly identical, and everywhere we had the feeling that they did not quite believe the answers.

Much of the "Western European" cloth-

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RUSSIA VISIT REVIEWED

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ing seen on some teenagers was rumored to have been traded from tourists for icons, black market rubles and souvenirs of Czarist Russia. This was part of a new generation of Russians, the youngsters who knew little of Lenin, less of war and not as much as they wished to know of the materialistic world outside.

Despite the giant steps taken toward 20th century comfort under Khrushchev, it became apparent that many of the old ways of secrecy and evasion lingered on in politics. As my visit approached the climax of meeting with Professor Vishnevsky, one cannot imagine the variety of excuses I heard from my Intourist guide as to why this meeting might not be possible, despite several months' advance notice of my proposed visit.

Since there were no telephone books, I had no way of calling him directly. It was said that if one person was supposed to call another, he would know the telephone number.

Arrangements had been made for me to spend a week with the Professor, but after four days of unsophisticated excuses, I became exasperated and told the chief Intourist official what I thought of their evasions. Arrangements were then promptly completed for a meeting with Professor Vishnevsky the following morning.

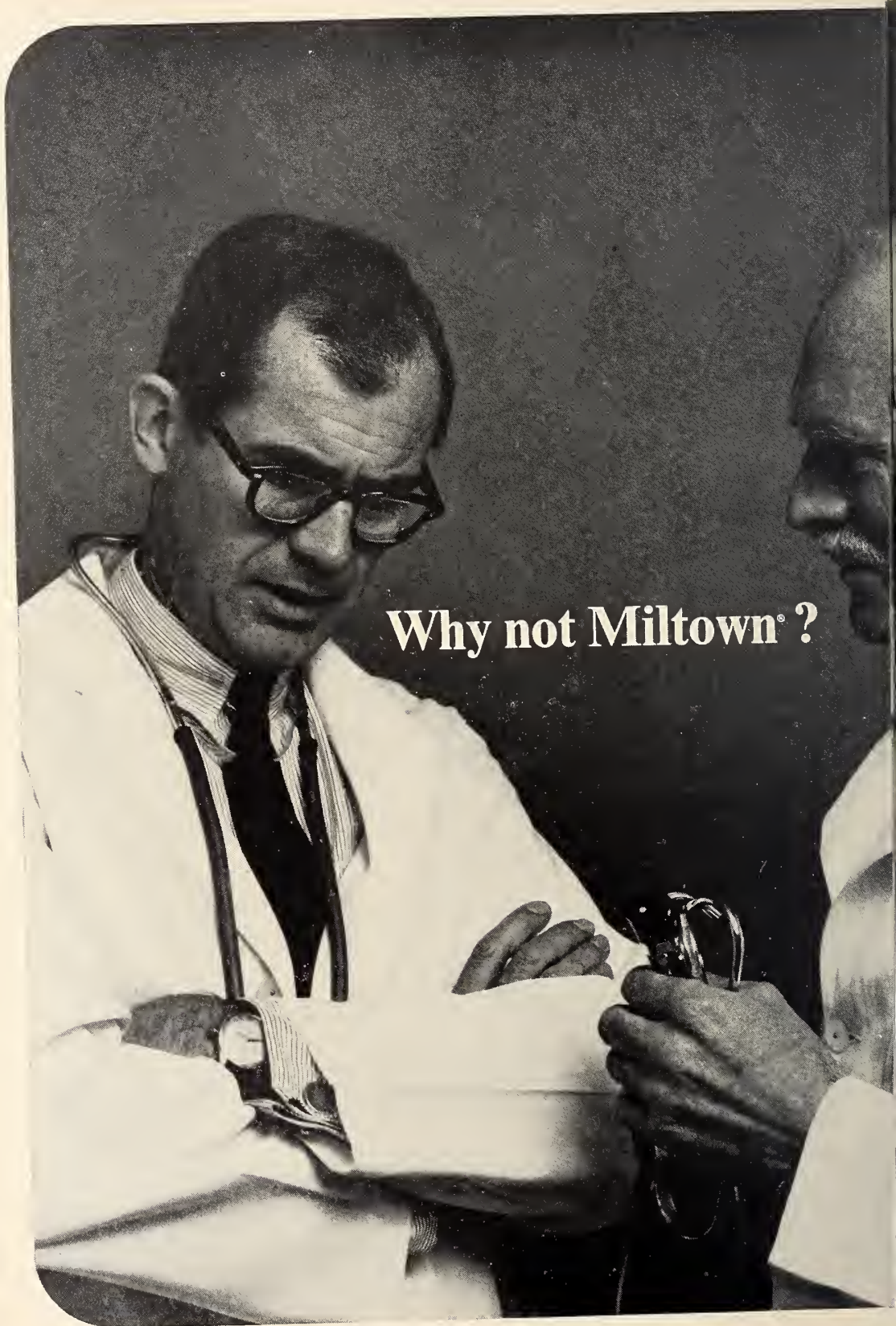
In the twelve hours preceding that meeting, I was telephoned at my hotel four times by various English-speaking officials to remind me of the importance of the Professor and to admonish me not to be late for our meeting. With this firmly in mind, I was ready and waiting at least one hour ahead of what would normally be necessary. In spite of these precautions, my Intourist guide and I were nearly an hour and a half late, due entirely to her inability to locate the Vishnevsky Institute for Surgical Research, the pride of Soviet Medicine.

Because of our tardiness, we were seated in the Professor's waiting room until he finished seeing his private patients. Such


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Effects and precautions: The transitory drowsiness which occurs with hydroxyzine HCl usually disappears spontaneously a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with high doses. Involuntary motor activity has been reported in hospitalized patients on a higher than recommended dosage. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as morphine, barbiturates, and anticoagulants. In conjunctive use with these drugs should be decreased. Because of the risk of respiratory depression, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Precautions and contraindications:** This dosage form is indicated only for I.M. or I.V. administration and should not, in any circumstances, be injected subcutaneously or intrathecally. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. Administration should be slow, no faster than 25 mg. per minute and should not exceed 100 mg. in any single dose. Paraflex should be used to insure injection only into intact tissue. In a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intra-arterial injection or periaxillary extravasation, both of which should be avoided. More detailed professional information available on request.

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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Before prescribing, consult package circular.

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RUSSIA VISIT REVIEWED

(continued from page 589)

practices, I was told, are restricted to professors, and the fees for consultations, house calls, and so on, are set by the government. It was interesting to observe these patients as we sat together in the waiting room. They were very well dressed, and much better looking generally than the average Russian seen on the street. Without exception, the men wore either military uniforms or the unmistakable signs of political occupation. The women all appeared refined and wore fashionable Western European styled clothing.

Despite the one-class social theory, we noticed that the Professor's attitude toward these patients of rank was that of graciousness and aristocratic charm, as compared to a rather curt aloofness he demonstrated later during ward rounds with clinic patients.

Touring the hospital with the Professor, I noted many differences between Soviet and American medicine. These included the common use of local anesthesia for major surgical procedures, use of cadaver blood for transfusions, and the frequent application of Pavlov's principle of conditioned response in the treatment of many organic illnesses.

However, as a plastic surgeon, I was most interested in observing their treatment of third degree burns. Skin grafting seemed to be done infrequently. Instead, following slough of the eschar, the burns were covered with a substance known as Vishnevsky Powder to promote rapid epithelialization. I asked the Professor's assistants as well as the ward officers just what the powder consisted of, but to my amazement, they were unable or unwilling to tell me the ingredients.

Hoping that I had not stumbled on a State secret, I took the question to Professor Vishnevsky himself. After a slight hesitation, he explained that it was desiccated (I believe lyophilized) cadaver skin. While the powder may truly have accelerated epithelialization, the problem of scar contractures remained a severe one.

The questions I put to Professor Vishnevsky and his associates and colleagues were almost entirely professional in nature. Only occasionally did they make professional inquiries in return. Instead, they wanted to know how many hours I worked each week? How much time did I have for vacations? What sort of housing accommodations did I have? How much did I charge for my surgical procedures? How much money did I earn a week? Did I own an automobile? How much money did a postman earn? Again, disbelief was their apparent reaction to most of my replies.

Throughout my visit, the Professor was extremely gracious and a hospitable host. In addition to personally making ward rounds with me two different days, he invited me on several occasions to observe his surgical procedures and seemed genuinely pleased whenever I photographed him. Observations of Russian surgical theaters have been so thoroughly reported by other American surgeons¹⁻⁵ that I will not go into further detail here.

From their replies to my queries, I came to realize that the physicians I spoke with were well aware of scientific advancements around the world, and even admitted to the generally backward state of Russian medicine by comparison. On the other hand, they pointed with justifiable pride to how far they had come in those few decades since the time when good medical care was available only to the aristocracy of the country. Now a good minimum standard of care was available to all.

This pervading conviction that "things are getting better all the time" was summarized by a Russian school teacher we happened to meet on the subway. She explained "To the Western visitor, our overcoats may appear extremely shabby—but at least everyone now has one!"

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Rx Reviews

and New Products

EXPERIMENTAL PNEUMONIA VACCINE

An experimental vaccine against primary atypical pneumonia, a serious disease in children as well as young adults in military camps or schools, has shown promise in animal tests, it was reported here today.

Drs. L. B. Senterfit and Keith E. Jensen, virologists of Chas. Pfizer & Co., Inc., made their report to the Federation of American Societies for Experimental Biology meeting here. They developed the vaccine on a research project under the auspices of the Board for Vaccine Development, National Institutes of Health, sponsored by the National Institutes of Allergy and Infectious Diseases. The new vaccine, a killed type, has successfully protected laboratory animals against this infection.

Primary atypical pneumonia is caused by a virus-sized organism: Eaton agent or *Mycoplasma pneumoniae*, which is not a virus but a bacterium and classed as a PPLO, or pleuropneumonia-like organism. Some authorities believe that as many as one out of five cases of pneumonia are caused by this organism, which is completely resistant to penicillin, although susceptible to the tetracyclines—broad-spectrum antibiotics. *Mycoplasma pneumoniae* has, until now, resisted attempts to control it by vaccine-induced immunity.

Until a few years ago, the cause of primary atypical pneumonia was unknown, but was thought to be a virus. Eaton agent was identified as a mycoplasma by Dr. Robert E. Chanock and Dr. Leonard Hayflick of NIH and Dr. Michael Barile of the Wistar Institute.

The new vaccine developed by Pfizer scientists has demonstrated results promising enough to sponsor further studies and tests, with eventual human trials projected for the future.

NEW DRUG TREATS EMOTIONAL STRESS WITHOUT LIMITING PATIENT ACTIVITY

Symptoms of environmental or situational stress in 300 patients were treated most effectively by oxazepam, a new anti-anxiety drug, Robert S. Warner, M.D., reports in a scientific exhibit at the meeting of the American Academy of General Practice last month.

During the three-year study summarized in the exhibit, 220 patients or 73.4 per cent of the group showed an "excellent" response to oxazepam, first member of a new series of compounds—the 3-hydroxy-benzodiazepinones (SERAX®, Wyeth Laboratories, not yet marketed). "Good" response was noted in 27 patients, while 35 showed a "fair" response. In 15 patients, the response was called "poor," and three of the patients reportedly became worse on this treatment.

The exhibit by Dr. Warner, a physician who practices in Coatesville, Pa., reports on treatment of patients from 11 to 83 years old in his regular practice. These 300 office patients displayed a variety of symptoms caused by environmental or situational stress such as anxiety, tension, irritability and agitation.

One advantage of the oxazepam therapy was, Dr. Warner reports, that the patient's symptoms could be relieved without limiting his mental or physical activity.

"Therapy to alter a patient's reaction to a stressful environment," his exhibit points out, "is often easier than changing that environment." Thus oxazepam "offers a significant new advance in the treatment of anxiety and related symptoms."

During these studies, Dr. Warner reports, two patients tried to commit suicide by taking overdoses of oxazepam. Both were be-

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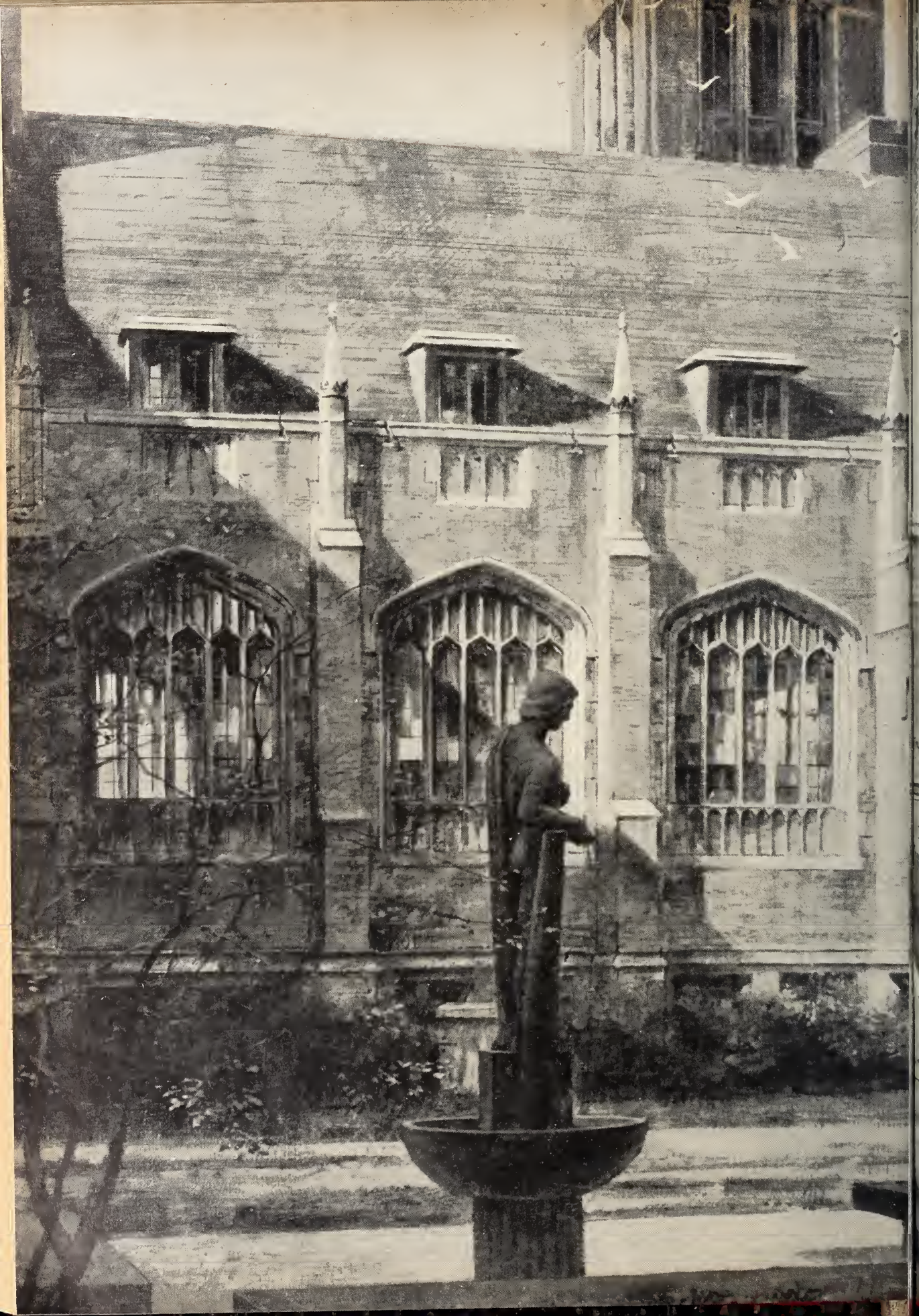
UNIVERSITY of ILLINOIS COLLEGE of MEDICINE

The University of Illinois College of Medicine is the newest addition to the E. R. Squibb & Sons' gallery of paintings of medical schools of the United States. A reproduction of the original painting appears on the following pages. The canvas has been presented to the University of Illinois College of Medicine and a reproduction suitable for framing will be sent to each alumnus.

Chicagoan Robert W. Addison, the artist, is represented in public galleries and private collections across the country. After graduating from the Art Institute of Chicago, he studied abroad and developed a skill and style in architectural painting that has won national acclaim and recognition. Addison is the recipient of many regional and national awards.

Dean Granville A. Bennett and Mr. Addison selected this particular area, enclosed by the slender piers, counterbalancing buttresses and graceful pointing arches so characteristic of the Gothic style of architecture as the most representative and familiar subject for the painting. Every graduate of Illinois' College of Medicine has visited the "courtyard" of the Library of Medical Sciences, where Aesculapius, the mythological god of healing, keeps his constant vigil. This statue is in honor of Alpha Omega Alpha Honor Medical Society.

The University of Illinois College of Medicine has had the distinction of graduating some of the most renowned of all American physicians. Squibb is honored to dedicate this painting to them and to every graduate of the school.





UNIVERSITY of ILLINOIS COLLEGE of MEDICINE

This painting of the University of Illinois College of Medicine is second in the series of original oil paintings of American medical schools commissioned by Collegia Medica Squibb.

Two miles west of Chicago's famous "Loop" in the very heart of the 305 acre Medical Center district, stands a medical college that ranks among the foremost in the country, the University of Illinois College of Medicine. Specific goals of this college have always been education, research and service.

The student body, 1200 faculty members and countless graduates of the University of Illinois College of Medicine are deservedly proud of the founders of their school. Those dedicated men exhibited remarkable perception in anticipating the inherent value of an affiliation with the University of Illinois.

When the Medical College became part of Illinois University, the need to develop and to improve the education and training of those who were to practice the art and science of medicine was realized. Such was the foresight that served as the foundation upon which to construct what is now one of the world's largest concentration of medical facilities, the West Side Medical Center in Chicago.

The House of Squibb is proud to make this lasting contribution to medicine by honoring the great colleges of medical education in America with the Collegia Medica Program.

SQUIBB



Squibb Quality — the Priceless Ingredient

Rx Reviews (cont'd from page 594)

ing treated with one 15 mg. capsule four times daily, but one patient took 50 capsules and the other 30 to 40 capsules in the suicide attempt. Both patients were hospitalized and slept 24 hours but did not require specific treatment.

"The addition of this new tranquilizer to the physician's prescription list," Dr. Warner said, "will allow greater flexibility in treatment of patients suffering from emotional stress. It will enable the general practitioner to aid patients who exhibit a variety of symptoms including anxiety."

ISUPREL FAVORED TO RAISE CARDIAC OUTPUT IN SHOCK

Hemodynamic studies in 20 patients treated for shock indicate that Isuprel (isoproterenol) decreases the heart's resistance load and, thereby, "increases the effectiveness of the heart as a pump," a group of McGill University researchers state in *Surgery, Gynecology and Obstetrics* (120:1, 1965).

Simple vasodilators such as ganglionic blocking agents decrease vascular resistance but do not increase cardiac output, according to Drs. Lloyd D. MacLean, John H. Duff, Hugh M. Scott and Dwight I. Peretz. They believe administering a vasoconstrictor in combination with a ganglionic blocking agent probably has the same, but somewhat slower, effect as using Isuprel alone.

Shock is defined by the authors as caused by "inadequate perfusion of vital organs" due to deterioration of cardiac function, inadequate blood volume or enlargement of the vascular space.

Isuprel, a sympathomimetic amine, not only "increased cardiac output but also tissue perfusion," as shown by increased urine output and drop in blood lactate observed in several patients, the report says.

"It was surprising to find that 10 of the 20 patients had a low cardiac output with high central venous pressure or cardiac filling pressure. The hemodynamic cause of

shock was cardiac in these patients even though this was suspected clinically in only 2 of the 10, with myocardial infarction and cor pulmonale respectively.

"In these patients further transfusion was not indicated, since the central venous pressure was elevated to 10 to 15 centimeters. The response in cardiac output to isoproterenol was gratifying and at times dramatic. . . ."

Isuprel, it is noted, raised cardiac output after certain vasoconstrictors had increased blood pressure, but not cardiac output.

Isuprel is manufactured by Winthrop Laboratories.

PRECOCIOUS PUBERTY CONTROLLED BY DRUG

Signs of precocious puberty regressed dramatically when small children afflicted with the syndrome received regular injections of a hormone drug.

Although a relatively small number of children is affected, precocious puberty may lead to serious emotional and physical problems in both patient and parents.

Fears that small girls may be sexually attacked and become pregnant beset older members of the family. But after treatment it was considered reasonable to assure parents "that the possibility of pregnancy is remote," California physicians report.

A study of 12 children—10 girls and 2 boys—was made by clinicians from the University of Southern California and Children's Hospital of Los Angeles. In the girls, breast development decreased or halted and vaginal bleeding virtually ceased.

Onset of symptoms, including various manifestations of precocious puberty, ranged from infancy to 7 years. The age span of children under treatment was 3 to 7 years. Each child was given regular injections of Depo-Provera (medroxyprogesterone acetate) for periods varying from 6 months to 2 years.

(continued on page 600)



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atropine-like action which should be considered when prescribing BENADRYL. **Side Effects:** Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in several forms including Kapseals containing 50 mg.

The pink capsule with the white band is a trademark of Parke, Davis & Company. 72465

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



Rx Reviews (cont'd from page 598)

"Without exception, the parents are well pleased with the results, and . . . not one patient has discontinued therapy despite the inconvenience of having to receive regular injections over long periods of time," the physicians reported in *American Journal of Diseases of Children*.

Breast development regressed in six of the girls after Depo-Provera and did not progress any further in the other four. Menstrual bleeding ceased in five of six girls who presented with this symptom and was reduced to occasional spotting in the sixth, according to Dr. S. A. Kaplan and other co-authors of the report.

Genital size regressed considerably in one boy but did not change significantly in the other. There was no change in the amount of pubic hair in any patient, the authors stated.

Before treatment, averages indicated that the children were gaining 1.8 years in height age and 2.6 years in bone age with each calendar year. With Depo-Provera, there was considerable individual variation, but average growth during treatment was reduced to 1.1 years in height age and 1.4 years in bone age per year.

The clinicians pointed out, however, that evaluation of the results is difficult because the number of patients was small and there were no simultaneous "controls."

Provera and Depo-Provera, developed in research laboratories of The Upjohn Company, are in wide use for the prevention of spontaneous abortion and for menstrual disorders.

In the precocious puberty study, the clinicians said there were no untoward reactions from the drug—in particular, no diminution of adrenocortical function or reserve.

"Administration of medroxyprogesterone acetate appears to be a promising form of treatment for constitutional isosexual precocious puberty in boys and girls," they said.

SYMPTOMLESS MEASLES VACCINE

A new one-shot vaccine which gives youngsters long-lasting protection against common measles with few or no reactions, has been announced by Pitman-Moore, Indianapolis pharmaceutical manufacturer and division of The Dow Chemical Company. The vaccine was licensed by the United States Public Health Service and shipments to druggists and physicians will start soon.

The new vaccine, called Lirugen, was developed by Dr. Anton J. Schwarz, head of Pitman-Moore's Virus Research.

(The live measles virus used in the vaccine is referred to as the "Schwarz strain.")

According to published scientific literature, Lirugen is the first live measles vaccine that precludes a simultaneous shot of gamma globulin. Gamma globulin has been recommended by manufacturers of other live measles virus vaccines to reduce the fever and rash produced by less-modified vaccines.

Dr. John Enders, noted scientist who first isolated the measles virus, has said that a live-virus vaccine ". . . to be employed without gamma globulin approaches most nearly to the criteria for an ideal prophylactic." Pitman-Moore's new vaccine has achieved this, and as Dr. Samuel Andelman, Commissioner of Health for the City of Chicago, reported, the Schwarz vaccine ". . . appears to be the most practical measles preventive at this time."

Lirugen has been extensively tested for over three years in clinical studies involving over 18,000 children. Because the vaccine is truly further attenuated than other live vaccines, fewer and lower fevers result after vaccination, even without using gamma globulin. At the same time, the vaccine has been proved 99% effective in protecting against measles as shown by recent large-scale field trials. A follow-up of children in early studies showed that immunity

(continued on page 602)

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FOR THE PATIENT WHO REALLY WANTS TO LOSE WEIGHT...

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all-day, optimum level, "trickle release" form.

***OBEDRIN MENU PLAN**—a common sense diet that solves the problem of calorie-counting while encouraging sustained good eating habits after weight reduction is accomplished.

Dosage is 1 tablet daily, usually at 10 a.m.

Supplied in bottles of 50 and 250 tablets, on prescription only.

Caution: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage. Use with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

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Rx Reviews (cont'd from page 600)

against measles could still be demonstrated two and a half years after vaccination.

There are two basic types of measles vaccines currently available—a live virus vaccine which produces long-lasting immunity, and a killed or inactivated vaccine which requires repeated injections to maintain immunity.

Although these earlier vaccines have been available since 1963, they have not been widely used, possibly because of the additional expense and inconvenience of giving gamma globulin with the live vaccine, and repeated injections necessary with the killed vaccine.

It is estimated that more than 20 million children under age 10 in the United States are still unprotected against measles. Because of the advantages of the new vaccine, it is hoped that more parents will be encouraged to protect their children against measles by having them vaccinated at an early age.

The common belief that measles is nothing more than a childhood nuisance is completely false according to public health agencies, and may account to a large degree for the apathetic attitude on the part of parents.

Common measles is a serious disease. Ninety-five percent of all children get it. It kills six times as many as polio.

Not one in 1,000, as sometimes supposed, but one in 15 may develop immediately a serious complication such as pneumonia, bronchitis, ear infection or neurological disturbance.

One out of every two children following a measles attack develops secondary complications—not life threatening, but leading to general poor health, increased need for medical attention, and interference with school work. Such conditions have been found persisting up to a year.

Recorded cases show that abnormal brain-waves occur in one-half of measles patients even without clinical signs of en-

cephalitis (brain inflammation). These abnormal brain-wave patterns soon revert to normal—but lasting damage may have occurred. According to Dr. Morten Andelman of the Chicago Board of Health: "There is growing evidence that this disease, even in mild form, may play a significant role as a cause of mental retardation, learning difficulties, and personality or behavior changes."

In the U.S., some 400,000 measles cases are officially reported in an average year. But the Public Health Service long has believed this represents only a small fraction of the real total. In 1963, the Surgeon General's Advisory Committee on Measles Control said without qualification: "In an average year, 4 million children in this country contract measles."

Dr. Schwarz who developed the vaccine has been Head of the Virus Research Department of Pitman-Moore since July 1, 1963. He is a native of Munich, Germany, and received his M.D. degree from the Ludwig Maximilian University of Munich in 1951 where he graduated with high honors. After coming to the United States in 1952, he held several important positions in medical research following his residency in general practice at the Dobbs Ferry Hospital in New York. As research associate at Children's Hospital, University of Cincinnati, he was assistant to Dr. Albert Sabin who is a well-known authority on virology. Dr. Schwarz joined Pitman-Moore in 1956 as Senior Virologist, and then became Assistant Department Head in 1960.

He has worked in many phases of virology and spent nearly six years in developing the measles vaccine which bears his name.

He is a member of the American Association for the Advancement of Science, the American Medical Association, Indiana State Medical Association, Marion County Medical Society, and the New York Academy of Sciences.

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Caffeine	30 mg.

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DOSAGE: *Adults and children over 12*—One to two tablets every 4 hours as needed. *Children 5 to 12*—One half the adult dose.

PRECAUTIONS: Patients should be warned not to drive an automobile or operate machinery should they become drowsy while taking PERCOGESIC-C. (PERCOGESIC-C contains phenyltoloxamine, which on occasion may produce such a reaction.) Dryness of the mouth and blurred vision have been reported on rare occasions following the use of homatropine methylbromide. Reduction in dosage or discontinuance of the drug should be considered if individual sensitivity of the patient becomes manifest. Although well tolerated and relatively safe, PERCOGESIC-C should be administered with caution to patients with glaucoma or other diseases with increased intraocular tension or urinary retention, and to patients with a history of sensitivity to any of its individual components.

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TODD-SANFORD CLINICAL DIAGNOSIS BY LABORATORY METHODS, Thirteenth Edition, Israel Davidsohn, M.D., and Benjamin B. Wells, M.D.

This standard textbook of clinical pathology, thoroughly revised, has for the first time become a work of several authors who are noted specialists in their respective fields. The text reads fluently. As in any endeavor as extensive as this, criticism may be directed at minute points of inadequacy. However, the book is more than adequate in the topics it emphasizes. It is especially satisfactory in the chapters on blood groups, in clinical chemistry, and on hepatic function.

Doctors Davidsohn and Wells should be complimented on having brought together the vast amount of information and data in one volume which is so well organized. This text is a must for each student of clinical pathology. Also the practicing physician, who is interested in more than just a cursory knowledge of the information which a laboratory provides and how it directly relates to his patients, will find this book particularly beneficial since it is so easy to read.

In summary, such a well established work should be readily available to the individual in his own library, as a reference in the clinical laboratory, and on the shelves of all medical libraries. This reviewer has used it for many years.

M. C. Wheelock, M.D.

AN INTRODUCTION TO PSYCHIATRY. Kurt Kolle, Philosophical Library, Inc. pp. 71.

The author of this small book is the occupant of the Chair at Munich that was long occupied by Kraepelin. This fact may have stimulated this translation. The translator's introduction indicates that it is intended primarily for the medical student and for the intelligent layman. The reviewer cannot endorse it for either purpose. It is inadequate for the needs of the first year medical student, and would be confusing to all but the best informed layman.

Some of the difficulties are due to translation. For example, the European term for General

Paresis, paralysis progressiva, is translated simply as paralysis. Since a considerable amount of space is devoted to the subject, the term paralysis as used is likely to cause confusion. The chapter on the classification of mental disorders is of dubious value as it includes a number of terms not current in American psychiatry, and uses an outline at variance with our standard usage.

While the author does include useful references to psychiatric history and gives credit to the present state of dynamic psychiatry, the book is not enhanced by such points as the author's frank advocacy of surgical castration as therapy for sexual deviation.

John Addam, M.D.

THE RETINAL VESSELS. By R. Seitz. Translated by Frederick C. Blodi. 186 pages, 363 illustrations. St. Louis, The C. V. Mosby Co., 1964. \$14.50.

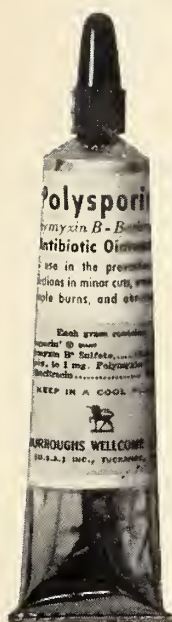
The examination of A-V crossings in the retina has long been an integral part of the work-up of a patient with vascular disease. Different eponyms such as Gunn's sign and Salus' sign have been applied to the variations in these crossings to designate degrees of venous compression, and these variations in venous distortion were held to have diagnostic and prognostic significance.

The author of this monograph, by carefully comparing the pre-mortem clinical appearance and the post-mortem histologic findings in the retinas of patients with a variety of vascular diseases, shows that there is really no such thing as venous compression. The "crossing phenomenon" is actually a thickened and dense perivascular connective tissue sheath which occurs in arteriosclerosis and has little relationship to hypertension. Further, one cannot safely assume that this special pathologic entity exists elsewhere in the body if it is found in the retina.

This slim book is recommended to all physicians who treat vascular disease. The excellent translation by Dr. Blodi is free of the Teutonisms that usually plague translations from the German, which makes the reading easy and pleasant.

David Shoch, M.D.

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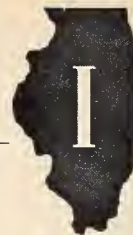
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NEWS and ANNOUNCEMENTS



Awards

Roland I. Pritikin, M.D., of Rockford, Illinois, received the Quetta Mission Hospital Medal in recognition of a quarter century of work in India and Pakistan as a visiting eye surgeon. Dr. Pritikin is President of the Henry Holland Hospitals Alumni Association and Fund. The mission hospitals are located throughout Pakistan and India.

Fellowships

Dr. S. R. M. Reynolds, professor and head of the Department of Anatomy at the University of Illinois College of Medicine in Chicago, will begin a three-month trip to South America in October under a Commonwealth Fund Fellowship.

During the trip, Dr. Reynolds will present lectures and attend conferences at medical schools, medical societies and research institutes in Mexico City; San Salvador, El Salvador; Lima, Peru; Santiago and Concepcion, Chile; Buenos Aires, Argentina; Montevideo, Uruguay; and Sao Paulo and Rio De Janeiro, Brazil.

As presently planned, he will speak at the Institute for Advanced Studies, the National Cardiological Institute; and the Pan American Endocrinological Congress when in Mexico City.

In San Salvador he will address a medical school faculty of medicine; and in Lima he will speak at the San Marcos University and National University.

In Montevideo, he will spend six weeks at the University of the Republic of Montevideo giving a course of lectures on fetal and neonatal circulation. While in Montevideo he will also conduct research with Dr. Roberto Caldeyro-Barcia of the Faculty of Medicine in the Uruguay school; and Dr. Uwe Freese of the Chicago Lying-in Hospital.

Grants

Eleven medical school faculty members last month were named to share in a grant of \$250,000 to maintain the high caliber of medical education in the United States and Canada.

The 12th annual Lederle Medical Faculty Awards were announced by Dr. Benjamin W. Carey, medical director of Lederle Laboratories, a Division of American Cyanamid Company.

Since 1954, Lederle has given more than \$7 million in the support of medical education, of which \$3.5 million has been allocated to 178 faculty members.

The awardees are selected by an independent committee composed of seven leading medical educators who have full authority for selecting the recipients. Chairman of the committee is Dr. Maxwell Finland, who is George Richards Minot Professor of Medicine at Harvard Medical School.

This year's recipients include: Dr. Martin Freundlich, Dartmouth Medical School; Dr. James C. Allen, Johns Hopkins Medical School; Dr. Howard K. Thompson, Duke University; Dr. S. H. George Allen, Albany Medical School; Dr. Arthur S. Kunin, University of Vermont.

Dr. Charles J. Goodner, University of Washington; Dr. Alkis J. Sophianopoulos, University of Tennessee; Dr. Richard K. Blaisdell, University of Chicago; Dr. William H. Hildemann, University of California at Los Angeles; Dr. Robert C. Rosen, Stanford University; and Dr. Ellis L. Rollett, University of North Carolina.

Committee members include Dr. Windsor C. Cutting, University of Hawaii; Dr. Harry F. Dowling, University of Illinois; Dr. Robert F. Pitts, Cornell University; Dr. George Sayers, Western Reserve University; Dr. Morris F. Shaffer, Tulane University; and Dr. Douglas H. Sprunt, University of Tennessee.

All Deans of medical schools in the United States and Canada are eligible to nominate candidates for the Lederle awards.

To discover how and why physicians become devoted to their professional specialties, the University of Illinois College of Medicine in Chicago is planning an intensive research program supported by a four-year \$119,572 grant from the United States Public Health Service.

Under the direction of Dr. M. Rue Bucher, assistant professor of sociology in the Department of Psychiatry, the research will include studies of psychiatric residencies, residencies in internal medicine, and Ph.D. programs.

The principal goal of the project will be to determine what produces a professional commitment—with emphasis on medical specialties.

Dr. Bucher, the first sociologist on the medical faculty, will be joined by two other sociologists who will work on this study of such variables as:

1—the professional philosophy of medical institutions and the people administering and directing them.

2—selection procedures of the specialty training programs in getting trainees.

3—types of experience provided and standards established.

4—interaction between the students and faculty.

5—social-psychological mechanisms which determine how individuals are affected by the training situation.

The study is being established to discover how doctors acquire their professional attitudes and learn what conditions are important in changing the individual to adopt professional goals. In addition, Dr. Bucher hopes to discover why certain professional careers are accepted as more prestigious than others.

Miscellaneous

The Summer Camp for Diabetic Children will be conducted for the seventeenth year under the auspices of the Diabetes Association
(continued on page 610)

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NEWS and ANNOUNCEMENTS

(continued from page 609)

tion of Greater Chicago from July 18th through August 8th, 1965 at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight through fourteen years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician, in addition to the regular counseling and domestic staff of Holiday Home.

June Clinics For Crippled Children

- June 2 Carmi—Carmi Township Hospital
- June 2 Alton Rheumatic Fever & Cardiac
—Alton Memorial Hospital
- June 2 Hinsdale—Hinsdale Sanitarium
- June 3 Springfield General—
St. John's Hospital
- June 4 Chicago Heights Cardiac—
St. James Hospital
- June 8 Peoria General—
Children's Hospital
- June 8 East St. Louis—
St. Mary's Hospital
- June 9 Champaign-Urbana—
McKinley Hospital
- June 10 Effingham General—
St. Anthony Memorial Hospital
- June 11 Evanston—St. Francis Hospital
- June 15 Belleville—St. Elizabeth's
Hospital
- June 16 Chicago Heights General—
St. James Hospital
- June 17 Rockford—St. Anthony's Hospital
- June 17 Bloomington (A.M.)—
St. Joseph's Hospital
- June 17 Elmhurst Cardiac—Memorial
Hospital of DuPage County
- June 18 Chicago Heights Cardiac—
St. James Hospital
- June 22 Peoria General—
Children's Hospital
- June 22 Effingham Rheumatic
Fever & Cardiac—
St. Anthony Memorial Hospital
- June 23 Springfield Cerebral Palsy (P.M.)
—Memorial Hospital
- June 23 Aurora—Copley Memorial
Hospital

Meeting Memos



May 20-22—More than 40 leading physicians, nurses and hospital administrators will participate in University Hospitals of Cleveland's Centennial Symposium in conjunction with the Hospitals' 100th anniversary year.

During the first day of the Symposium, speakers will examine the functions and responsibilities of the university affiliated teaching hospital in the community, in graduate and undergraduate education and in research.

In a special evening session, to which the public is invited, Dr. John S. Millis, President of Western Reserve University,

will discuss "The Response of the University Hospital to Its Changing Responsibilities."

The second morning of the Symposium will be devoted to three critical areas of medical research: immunology, psychosomatic medicine and the population explosion. Dr. Irving Page, Director of the Research Division of Cleveland Clinic, will conclude the session with a discussion of the probable direction medical research will take during the next 100 years.

The remainder of the three-day Symposium will be devoted to seven separate departmental meetings.

(continued on page 613)

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Physician's Philosophy of Life

An article by Dr. Franklin D. Yoder of Springfield, Ill., Director, State of Illinois, Dept. of Public Health, that recently appeared in the Rocky Mountain Medical Journal and was reprinted in the Bulletin, Sangamon County Medical Society, Ill., intrigued me. The following is an excerpt:

I find myself fascinated by some of the work of Dr. Edward L. Bortz of Philadelphia, the former president of the American Medical Association, and a senior consultant in medicine at Lankenau Hospital. He has written extensively about how people should be able to live past 100 years of age but when asked by a news magazine to write a paper on how to stay young he refused, saying, "I'm not interested in discussing 'arrested development.'" In other words, it isn't a problem of staying young, it is how to make our lives more useful. My philosophy in this regard is that when man retires from life, life retires from him. I think we can divide our life span of 100 years into approximate trimesters, using a period from birth to 30 as training, from 30-65 to do a first life work, rear a family, and acquire competence. From 60-65 to 90 embark upon a second career and consider possible retirement at 85 or 90.

I hope that all of us working in medicine with the allied health professions and services can contribute to mankind's benefit by not only making life longer, but more scientifically and socially useful. We must also work in the belief that preservation of human dignity and individual liberty is the best method of preserving our free western society.

It would appear that I, unknowingly, have been trying to live Yoder's (and Bortz's) philosophy of life. I finished the first trimester at 27; was compelled to finish the second, devoted to the practice of radiology, medical editing and postgraduate medical education at 68 (1959), because of a coronary episode; the third trimester is being devoted to helping motivate talented youth to achieve academic excellence and secure a college education; recently, this has been supplemented by helping older persons to achieve meaning and purpose in their lives—dynamic retirement. Apparently I lingered a bit too long (41 years) in the second trimester, as I do not believe I'll make it to 100 or even 85 years. As a physician, however, I have that inborn desire, not only to prolong life but to increase its vigor, efficiency and happiness.

Harold Swanberg, M.D., Quincy

Meeting Memos —continued

May 21-23—The Tri-State Meeting of the Illinois, Iowa, and Wisconsin Associations of Blood Banks has been scheduled at the Clayton House Motel in Davenport, Iowa.

The program of the meeting of the three state organizations will be directed toward the interests of blood bank technicians and will emphasize the practical aspects of blood banking.

Dr. W. S. Pheteplace of Davenport, Iowa is program chairman for this meeting. Mr. S. L. Moinichen of Cook County Hospital in Chicago will present "Instant Workshops" during the first day's session. On the second day, May 22, Clara V. Hussey, M.D. of Marquette University School of Medicine in Milwaukee will talk on the "Treatment of Coagulation Problems with Blood Products."

Inquiries with regard to registration should be sent to Mrs. Elizabeth G. Parker, Secretary-Treasurer of the Iowa Associa-

tion of Blood Banks, Community Blood Bank of Central Iowa, 1119 Woodland Avenue, Des Moines, Iowa.

May 23—A review of the American Association of Blood Banks and what makes it click will be discussed by Robert E. Klein, M.D., President of the American Association of Blood Banks at the Tri-State Association of Blood Banks meeting in Davenport, Iowa.

Director of Pathology and Medical Director of the John Henry Thomas Memorial Blood Bank in Gainesville, Florida, Dr. Klein has been an active participant in blood banking for many years.

Dr. Klein's address will also be an Interim Presidential Report and will deal primarily with the structure of the American Association of Blood Banks and how member associations can best utilize its facilities.

(continued on next page)

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 COLON SURGERY, One Week, May 24
 BASIC PRINCIPLES IN GENERAL SURGERY,
 Two Weeks, July 12
 BOARD REVIEW COURSE IN SURGERY, Part II, August 2
 PROCTOSCOPY & SIGMOIDOSCOPY, One Week, July 12
 VARICOSE VEINS, One Week, July 12
 SURGERY OF HAND, One Week, September 13
 FRACTURES & TRAUMATIC SURGERY, Two Weeks, June 7
 GYNECOLOGY, Office & Operative, Two Weeks, June 7
 VAGINAL SURGERY, One Week, June 21
 GYNECOLOGICAL MALIGNANCIES, One Week, May 24
 OBSTETRICS, General & Surgical, Two Weeks, July 12
 BOARD REVIEW COURSE IN MEDICINE, Part I, September
 13; Part II, June 14
 HEMATOLOGY, One Week, June 14
 CLINICAL ENDOCRINOLOGY, One Week, June 7
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Meeting Memos

(continued from page 613)

The Tri-State Association of Blood Banks is made up of physicians, technologists, and administrators representing blood banks in Illinois, Iowa and Wisconsin.

Meetings are scheduled for May 21, 22, and 23, 1965 at the Clayton House Motel in Davenport, Iowa.

May 24-25—The Department of Pediatrics of the University of Cincinnati College of Medicine will give its Second Annual Postgraduate Course in Pediatrics on May 24 and 25, 1965. This course entitled "Pediatric Aspects of Surgery in Childhood" will be devoted to advances in diagnosis of pediatrics surgical problems and in the pre and post operative care of children. In addition to a series of lectures, the course will feature a series of informal small group sessions of 5-6 participants on related topics and recent advances in general pediatrics.

The faculty and topics for discussion will include Dr. Wm. Altemeier, Present Day Management of Staphylococcal Infection; Dr. Norton Dock, Psychological Aspects of Elective Surgery in Children; Dr. Samuel Kaplan, Indication and Contraindication to Surgery in Ventricular Septal Defect; Dr. Lester Martin, Recent Advances in Tumor Management; Dr. Alvin Mauer, Splenectomy and Post Splenectomy Infections; Dr. Robert McLaurin, Congenital and Traumatic Lesions of the Central Nervous System; Dr. Bruce McMillan, The Program of the Shriner's Burn Institutes; Dr. Wm. Schubert, Surgical and Non-surgical Causes of Malabsorption Syndrome; Dr. Frederic Silverman, Present Day Concept of Congenital Dislocation of the Hips; and Dr. Clark West, Fluid and Electrolyte Management in the Surgical Patient.

Registration will be limited to 50 physicians. The registration fee is \$50.00.

Address all inquiries to Dr. Wm. Schubert, The Children's Hospital, Cincinnati 29, Ohio.

OBITUARIES

Siegfried Bien*, Elgin, died April 6, aged 63. A graduate of Medizinische Fakultät der Universität, Vienna, in 1927, he specialized in psychiatry. He was a staff member of Elgin State Hospital.

L. D. Dusch, Golconda, died March 6, aged 76. In 1914 he was a graduate of the University of Illinois College of Medicine, specializing in plastic surgery.

Curtis A. Hunsaker, Danville, died March 24, aged 77. A graduate of Bennett Medical College in 1908, he graduated from the University of Chicago Eye, Ear, Nose & Throat School in 1921. He specialized in both neuro-psychiatry and E.E.N.T. until his retirement in 1953.

H. N. Jarvis, Harrisburg, died March 15, aged 82.

Ellis K. Kerr*, Oak Park, died April 11, aged 90. In 1900 he was a graduate of Northwestern University Medical School. Doctor Kerr was one of

the founders and the first chairman of the medical staff of West Suburban hospital, a charter member of the Chicago Society of Internal Medicine and the Institute of Medicine of Chicago, an associate professor of medicine at Rush Medical College and an honorary fellow of the Institute of Medicine of Chicago. He was an emeritus member of ISMS.

David D. Kirby, Peoria, died March 14, aged 82. A graduate of St. Louis College of Physicians & Surgeons in 1907, he specialized in neurology. He practiced in Peoria for 27 years and retired in 1936.

Erwin Klein*, Chicago, died April 1, aged 66. A graduate of Medizinische Fakultät der Universität, Vienna, in 1924, he specialized in roentgenology. He was a staff member of Weiss Memorial hospital since 1940 and was a member of the Chicago Roentgen Society, the Radiological Society of North America and the American College of Radiology.

(continued on next page)

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John F. Korecki, Glenview, died October 16, aged 80. He was a graduate of the Chicago Medical School in 1921.

Frank Kostal*, Lombard, died November 3, aged 78. A graduate of Rush Medical College in 1920, he was on the staff of the West Suburban hospital, Oak Park.

Gilbert H. Marquardt*, Chicago, died March 26, aged 61. In 1928 he graduated from Northwestern University Medical School and specialized in internal medicine. He was chief of staff at Wesley Memorial hospital in 1941 and 1946 and was senior attending physician at the time of death. He was also an associate professor of medicine at Northwestern University Medical School and chief consultant at the Oak Forest division, Cook County hospital and a consultant at Henrotin hospital. He was a fellow of the American College of Physicians and a member of the National Committee for Stroke.

Eugene N. Marx*, Chicago, died March 22, aged 69. In 1926 he was a graduate of the Universitat Koln Medizinische Fakultat, Cologne, Germany.

Thomas J. Murphy*, Decatur, died March 16, aged 61. A graduate of Loyola University School of Medicine in 1930, he specialized in surgery. He was president-elect of the medical staff of St. Mary's hospital and was also on the staff of Decatur and Macon County hospital. He retired in 1946.

William G. Sachse, Morris, died December 10, aged 82. In 1908 he was a graduate of Rush Medical College.

Otto C. Schlack*, Sarasota, Florida, formerly of Chicago, died April 4, aged 75. He was a graduate of Loyola University School of Medicine in 1912. He was Chicago city police surgeon, medical director of Cook County Tuberculosis hospital for 30 years and the founder of the American College of

Chest Physicians. He was an emeritus member of ISMS.

John W. Seids*, Moline, died March 13, aged 93. A graduate of Western Reserve University School of Medicine, Cleveland, in 1898, he specialized in colon and rectal surgery. Doctor Seids had been a Rock Island County physician for over 65 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

A. Howard Shanberg, Chicago, died December 17, aged 66. He was a graduate of Rush Medical College in 1923.

Eli N. Stenn*, Chicago, died April 11, aged 86. A graduate of the University of Illinois College of Medicine in 1907, he served with the Chicago Board of Health for 50 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Konstantz Swider*, Chicago, died March 13, aged 57. In 1933 he was a graduate of the Universitatas Regele Ferdinand 1-iu din Cluj Facultatea de Medicina si Farmacie and specialized in psychiatry.

Eugene S. Talbot*, Chicago, died April 2, aged 80. In 1910 he was a graduate of Rush Medical College where he later joined the faculty. In 1950 he became assistant medical professor emeritus at Northwestern University and was also on the staffs of Presbyterian-St. Luke's and Passavant Memorial hospital when it opened in 1929. He was an emeritus member and a member of the Fifty Year Club of ISMS.

William Tate, Jr., Chicago, died March 8, aged 75. Former head of obstetrics and gynecological department at Provident hospital, he retired in 1960.

Robert E. Widerborg*, Chicago, died March 29, aged 55. A graduate of the University of Illinois College of Medicine in 1935, he specialized in obstetrics and gynecology.

**Indicates member of Illinois State Medical Society.*





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Illinois Medical Journal

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— president's page —

Burtis E. Montgomery, M.D.

THE TORCH HERE PASSED

AS LAST MONTH'S "President's Page" represented one of the last official communiques of Dr. Piszczek as our president, so this month's page represents one of my first.

The torch Dr. Piszczek has passed on to me as your president, kindled by your support and confidence, is a bright one. Set by an administration of wisdom, of foresight and of planning, it has lit paths to the future which I ask you to follow with me for the next year.

Hopefully, these paths will lead to greater participation in Society matters by all of us. Never before has such activity been so vital to the preservation of professional ideals which we hold so sacred and which now are in such imminent danger.

Hopefully, too, they will lead to better identification between the Society and the total medical problems of the public. In the solution of these problems we must assume leadership, informing the public of our existing aims and goals. With true clarity of purpose, we must inspire other groups in consolidating our mutual goals and in implementing our activities.

If we are to brighten our public image,

we must become more familiar with the environmental situations of our patients. Only by reassuring the patient of our willingness to respond to his many needs will we be able to contribute to the fulfillment of this aim.

Of primary importance, we must concentrate our attention on the magnitude of anticipated changes in health care services which would be brought about if HR 6675 becomes law. Our guide along the proper path in this area should be based upon these principles:

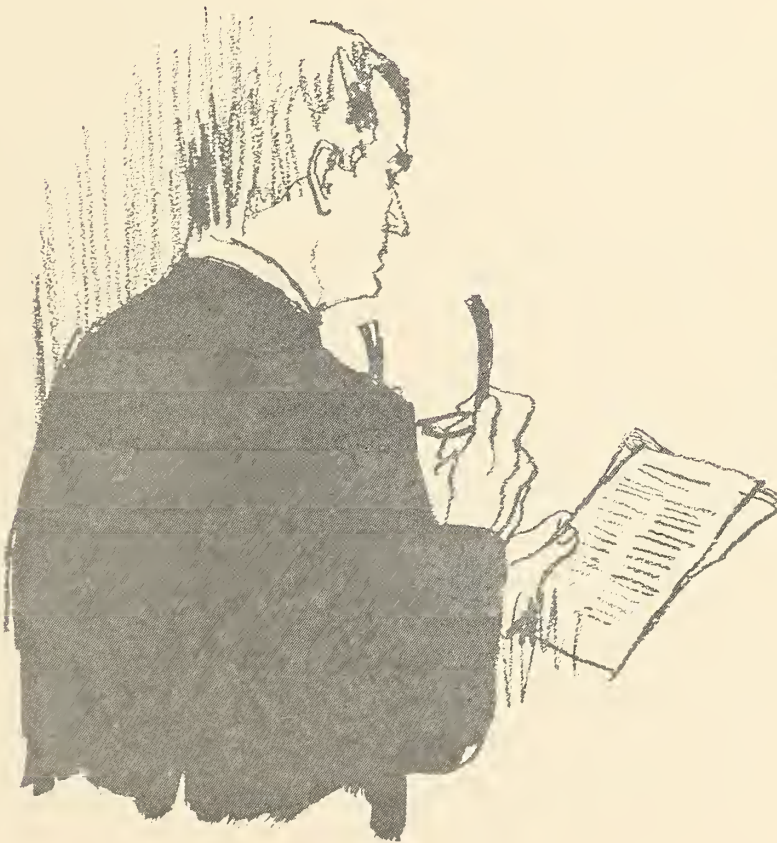
1. We must be permitted by the government to collaborate with its department on all matters affecting the administration of Federal medical care problems.

2. We must be permitted total independence from government in our scientific and technical committees so important to our practice of medicine.

3. We and our patients must be assured the confidentiality of medical records.

In the enactment and preservation of these principles over the next year, I beseech the continued and unqualified loyalty of each and every member of our Society. I pledge that you have mine.

SUMMARY OF ACTIONS



1965 HOUSE OF DELEGATES

1965-1966

OFFICERS AND BOARD

Officers

President	Burtis E. Montgomery, Harrisburg
President-Elect	Caesar Portes, 25 E. Washington St., Chicago
1st Vice President	Michael R. Saxon, Oswego
2nd Vice President	Casper Epsteen, 25 E. Washington St., Chicago
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Speaker	Edward W. Cannady, 4601 State St., East St. Louis
Vice Speaker	Maurice M. Hoeltgen, 1836 W. 87th St., Chicago

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	Frank J. Jirka, Jr., 1507 Keystone Ave., River Forest.....1968
	Philip Thomsen, 13828 Lincoln Ave., Dolton.....1966
	J. Ernest Breed, 55 E. Washington St., Chicago.....1966
	William E. Adams, 950 E. 59th St., Chicago.....1967
	Ted LeBoy, 330 Gale Ave., River Forest.....1967
4th District	Paul P. Youngberg, 1520 Seventh Ave., Moline.....1967

5th District	Darrell H. Trumpe, St. John's Sanatorium, Springfield.....1967
6th District	Newton DuPuy, 1101 Maine St., Quincy1966
7th District	Arthur F. Goodyear, 142 E. Prairie Ave., Decatur.....1967
8th District	Wm. H. Schowengerdt, 301 E. University Ave., Champaign1967
9th District	Charles K. Wells, 117 N. 10th St., Mt. Vernon1966
10th District	Willard C. Scrivner, 4601 State St., E. St. Louis.....1966
11th District	Joseph R. O'Donnell, 444 Park, Glen Ellyn1968

Trustee-At-Large	Edward A. Piszczek, 6410 N. Leona Ave., Chicago
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Chairman of the Board	William E. Adams, 950 East 59th St., Chicago
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AMA Delegates	(elected to take office on January 1, 1966) H. Kenneth Scatliff, Walter C. Bornemeier, Frank H. Fowler, Arthur F. Goodyear, Harlan English, Edward W. Cannady
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AMA Alternates	(elected to take office on January 1, 1966) Harold A. Sofield, George C. Turner, Edward A. Piszczek, Newton DuPuy, Jacob E. Reisch, Carl E. Clark
----------------	--

ADMINISTRATIVE ACTIVITIES

Report of the President

Medical education concerned the President, Dr. Edward A. Piszczek, and his report to the House (approved by official action) contained a general assessment of plans to develop two new medical schools in Illinois. Park Ridge would be the site of the four year school sponsored by the Lutheran Church, a possibility within the next four or five years; and Carbondale would provide the location for a two year medical school for Southern Illinois.

Report of Secretary-Treasurer, and other officers

The Secretary-Treasurer's report gave general information to the delegates on the Society, where its dollars came from and how they were spent in the best interests of the public and the profession.

Special attention was given to the Journal and the excellent efforts of the Division on Publications and Scientific Service to improve standards, not only in the scientific content, but also in the quality and quantity of advertising in its pages.

The Speaker and Vice Speaker of the House were commended for their innovations in procedure. The presentation of resolutions by title prior to assignment to Reference Committees conserved time, and the presentation of nominations for the election of officers and committees was another method of expediting the business of the House. The effort to develop a new method of presentation of committee reports was not entirely successful but it is the expressed opinion of the Speaker that as it becomes better understood, the House will benefit by this additional clarification and simplification of its business procedures.

The report of the Chairman of the Board as printed in the Handbook reflected the amount of work, the competence of the Trustees and the infinite amount of detail handled throughout the year.

The ELDERCARE program was forcefully and effectively handled; the informational campaign authorized at the called meeting of this House on February 7, 1965, carried the story of medicine's concern for the health and welfare of the residents of Illinois throughout the State.

The enforcement of the Medical Practice Act was stressed by the Chairman of the Board. All physicians treating patients in Illinois must be licensed to practice. Some unlicensed physicians employed in hospitals have failed their licensure examinations five to twenty times.

The Board has developed liaison with the DEANS OF THE FIVE MEDICAL SCHOOLS. For the past two years the officers have met with the representatives of the five schools and discussed mutual problems and mutual aims. It is the sincere hope of both groups that the "town and gown" elements will find understanding and be able to offer solutions to the many problems faced

by academic institutions and by physicians in the practice of medicine today.

The report of the Executive Administrator reflects the efforts of five years in efficient administration; the growing esprit de corps developed by members of staff, and the excellent relationship between Board members and the employees at the headquarters' office.

The House approved the recommendation of the Reference Committee to contribute \$2,000 to the Health Careers Council for the present year, 1965, and to continue with the group, contributing \$1,000 annually.

SPECIAL REPORT OF THE FINANCE COMMITTEE

The Finance Committee report presented the projected financial needs of the Illinois State Medical Society for the next five years. The study included realistic efforts to provide sound financial management, a balanced budget, and to continue the best program available for the members of the Illinois State Medical Society. The Reference Committee spoke in a forthright manner advocating the anticipation of future needs, perhaps the curtailment of some current programs, and a careful management in the field of Public Relations, Legislation and Public Affairs and the Springfield Office, covering some \$248,700 in Society funds.

In the future, the Board of Trustees was asked to require any resolution providing for the expenditure of funds, to be accompanied by a recommendation for the provision of such new funds.

The House approved the establishment of a new standing COMMITTEE ON ADMINISTRATIVE SERVICES of the House of Delegates, to be elected by the House and to report to the House on a quarterly basis. The area in which this committee is to be concerned involves matters of the budget and the administrative services to the Society. The House referred this request to the Committee on Constitution and Bylaws for the necessary preparation, and to be submitted in 1966 for House action.

The Reference Committee recommended that the Reference Committee on Administrative Services be composed of six members, elected for staggered terms so that at least two shall have served on the committee the preceding year. This also was referred by the House to the Constitution and Bylaws committee.

The House approved a suggestion presented by the Chairman of the Board, that Emeritus members and Retired members could be asked to make voluntary contributions to organized medicine. The ISMS was instructed to adopt the policy of contacting these members for voluntary contributions to IMPAC-AMPAC.

The 1966 Dues Structure

The House approved recommending to the Board of Trustees the following dues structure, on which the Board might base its request to the House for

the 1966 annual dues. After animated discussion and a general summary of the budget needs, the importance of the AMA-ERF and the use of these unrestricted funds by the deans of the five medical schools; the importance of building up the seriously depleted Society reserves; the necessity to maintain the Society legislative, scientific, economic programs—the following dues structure was approved for the consideration of the Board and subsequent recommendation for House action at the closing session on Wednesday:

TOTAL DUES.....	\$105.00
broken down as follows:	
General Fund	\$ 70
Benevolence	\$ 7
AMA-ERF	\$ 20
Society reserve	\$ 8
	<u>\$105</u>

Then a request was approved for a VOLUNTARY CONTRIBUTION to IMPAC-AMPAC of an additional \$25.00. A copy of the report of the Finance Committee which was distributed to the House of Delegates, will be published in the Journal.

The House suggested that \$1 per year for five years be taken from the \$8 assigned to the reserve funds, for the support of the ISMS-Medical Historical Museum in Springfield, PROVIDED adequate financial support can be obtained OUTSIDE the Illinois State Medical Society by the time the necessary contracts are ready for signature.

The Reference Committee also recommended that the development of a contingency reserve was desirable.

The Reference Committee felt that a reduction of \$5 in funds assigned to Medical Benevolence Committee could be realized in 1970.

The consensus was that the deans of the five medical schools should make a short report annually to the House of Delegates outlining how the AMA-ERF funds have been expended. While there was no request to restrict the use of the funds, it was felt that the five schools where the majority of the Illinois money is allocated, should submit an outline of how the money has been utilized. Without this statement, it leaves the Society with approximately \$190,000 unaccounted for, with no detailed information for the membership. The individual dean accepting the checks for the schools has always outlined his own usage of the funds, and given the House general information about the other four schools, but in order to provide all members of the House (or the Society through publication in the annual reports in the April issue of the IMJ) the Committee on Medical Education will be asked to include this information in its report to the House in 1966.

CONSTITUTION AND BYLAWS

Only one change of particular consequence was made in the Bylaws by the Reference Committee

and approved by the House. In the future, the Speaker of the House of Delegates of ISMS will have the privilege of appointing the Reference Committees for the House over which he presides.

The appointment of any ad hoc committees will be made by the President of the Society.

There were other changes relative to the appointment of officers of Scientific Sections, a general outline of "distinguished members" and their election and privileges under the Bylaws; and provisions were made to allow "physicians residing in a state other than Illinois, but practicing *principally* in the jurisdiction of an Illinois county," to become members of the ISMS. This last provision resulted from an inquiry originating in Rock Island County.

Committees are now officially authorized (with the consent of two-thirds of the members) to conduct business or hold meetings by mail or conference call "PROVIDED ALL MEMBERS OF THE COMMITTEE are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all committee members."

It is hoped that this will help eliminate the unfortunate practice of a few chairmen of committees reporting for their committees without formal meetings, minutes and customary procedure.

Several important matters were referred to the Committee on Constitution and Bylaws by the House, and will be prepared for the consideration of the 1966 membership.

The County medical societies will be notified of the number of delegates to the House to which they are entitled, as of active membership on December 31 of the preceding year. This notification will be sent during January of the current year.

PUBLIC RELATIONS

This annual meeting of the House of Delegates saw the first anniversary of the creation of the corporate symbol of medicine in this State, DR. SIMS. Dr. Sims represents another "first" for the Division of Public Relations.

The Reference Committee also noted that Illinois has been first in the use of outdoor advertising; in developing a monthly health column for high school papers, "DR. SIMS Talks To Teens"; in the use of transit advertising on Chicago buses and subway trains; and soon hopes to develop the first coloring book for children, in which DR. SIMS will help small youngsters understand a visit to their physician's office.

The Illinois Medical Assistants Association has been helped to develop a program of growing interest. The headquarters office has assisted in the publicizing of their efforts, and has helped in coordinating projects channeled through the ISMS.

This division is active in several fields—works with the Grievance Committee, the Fifty Year Club Committee, the Ethical Relations Committee,

the Physicians Placement Service, and had worked throughout the year to strengthen the bond between the medical profession and the clergy through its Committee on Medicine and Religion.

The Committee on Rural Health and Student Loan Fund has worked with the Illinois Agricultural Association to provide additional physicians for the rural areas of Illinois. The committee has been responsible for the medical education of some 121 physicians.

The Reference Committee expressed appreciation for the work of the committees, and congratulated "DR. SIMS" on his unusual success achieved in only a year.

PUBLICATIONS AND SCIENTIFIC SERVICES

The Reference Committee recognized the difficulties faced by the Committee on Scientific Assembly in the planning of programs for the annual meeting. They recommended that the suggestions made by the committee be implemented.

The reports of the Editor, the Journal Committee and the Editorial Board were considered by the Reference Committee which expressed to the House the sincere hope that a build-up in Journal funds would result in an even stronger Journal for our membership.

The Maternal Welfare Committee and the Joint Committee on Perinatal Mortality, under the chairmanship of physicians interested in continuing the outstanding work of these committees, have continued to lower the mortality rate in maternal and infant cases. Dr. Hartman gave the details of the master plan for cooperation with some ten different organizations to reduce the maternal and perinatal mortality statistics in Illinois.

The control of tuberculosis, the activity of the Committee on Radiation, the importance of water pollution, and the work in the field of nursing, were all reviewed carefully. The correspondence schools of nursing were discussed in detail and Dr. Scrivner pointed out the importance of the junior college nursing program as a means to combat the shortage of nursing personnel throughout Illinois.

Eye Health, Mental Health (both the report of the committee and the Director of the State Department), Public Health and Nutrition, Medical Education, and Continuing Education, were discussed carefully.

The Committee on Continuing Education has requested the House to consider recommending that the honorarium for speakers be increased from \$25 to \$50. This request of the committee was approved by House action.

Resolutions came to this reference committee from various sources. . . . Winnebago County resolution proposing a study of legalized abortion was referred to the Board of Trustees for study.

The group of resolutions from DuPage County and from Chicago Medical Society, and Henry Stark County Society dealing with the basic problems of physician shortage, and physician educa-

tion were combined into one substitute resolution which provided:

That the Committee on Medical Education of the ISMS, together with such additional personnel deemed advisable by the Board, be instructed to meet frequently and on a continuing basis, with the representatives of the faculty and administration of all Illinois medical schools, with the aim of exploring and documenting the mutual problems, and undertaking such remedial measures as can be implemented. The committee is to report quarterly to the Board and annually to the House.

Dr. Brislen called the attention of the House to the fact that the Bylaws already provide for reports to the Board, and annual reports of all standing committees to the House.

The report of the Ad Hoc Committee on Oral Contraceptives made its report to the House in detail, and the "guidelines to assist the practicing physician" were approved by the official action of the House.

ECONOMICS AND INSURANCE

The Division of Economics and Insurance reported a year of activity. The Committee on Aging was complimented by the Reference Committee for the fine work it is doing. The Committee recommended (and the House agreed) to support the establishment of more home care programs throughout the state. The House urged that Blue Cross and insurance companies participate in the program.

Concurrent care was specifically defined—since it differs from consultation services in that two or more physicians may provide medical care to one patient for different health problems, and each be paid.

The Reference Committee concerned itself primarily with the problems in the field of public aid. Mr. Harold O. Swank, Director of the State Department, gave detailed information to all in attendance on the position of the Department in whatever field was brought up for discussion. He courteously considered whatever criticisms arose as a matter of information and future use.

The Reference Committee recommended to the House that whenever another supplemental list to the Drug Manual is contemplated, the Department of Public Aid be asked to bring the Manual up-to-date and republish it to include all changes and additions. It was felt that this would make it far more effective and more easily used.

Mr. Swank testified that the use of the Manual had resulted in a decrease in the cost of drugs to the Department of approximately \$120,000 per month. The Reference Committee at this time favored the retention of the Drug Manual, but felt that as additional drugs were added to the list, eventually the need for the Manual would disappear.

Mr. Swank reported that he was in favor of the payment of physicians in Cook County who do not receive fees at this time for in-hospital care of public aid patients. The money for this program has been allocated and the Budgetary Commission and Governor Kerner have approved the plan. This matter is now in the hands of the Illinois General Assembly.

Dr. Henry A. Holle has been employed as Medical Director by the Department of Public Aid to review medical practices in the treatment of public aid patients.

The House approved a directive to enter into negotiations with the Department of Public Aid to develop a more equitable fee scale based upon the scope of medical care available, and incorporating the principles of the ISMS Relative Value Study.

The House recommended that county medical societies be encouraged to appoint liaison committees with local hospital representatives and review problems of mutual concern.

The Emergency Room Services are to be studied by a committee composed of members of ISMS and the IHA.

The House complimented the Committee on Medical Economics for setting up the Retirement-Investment program for our membership and also for obtaining the Group Major Medical Expense Plan coverage.

An economic newsletter "sounded interesting and should be informative."

A resolution from Winnebago County Medical Society which protested the inclusion of payment for blood and blood plasma under the Society's Group Major Medical Expense Plan was approved. Payment for blood and blood plasma will be deleted from the Group Major Medical Expense Plan, and a resolution of a similar nature will be taken by the ISMS delegates for presentation to the AMA House at the New York meeting in June.

The use of the new simplified claim form was outlined. When a physician receives a long complicated form, he is advised to complete instead the simplified form, attach it to the original and mail both to the company. If the company insists on the completion of their form, then the physician should notify the insurance company that he will complete it subject to a fee.

The House did *not* approve the use of the Relative Value Study as the basis for fee negotiations in the event HR 6675 or similar legislation were enacted, "and that physicians be reimbursed for their services at no less than \$5 coefficient," since this recommendation was contrary to past actions taken by the House not to establish a coefficient on the Relative Value Study.

LEGISLATION AND PUBLIC AFFAIRS

The House considered the report of the Committee on Archives which is endeavoring to establish a Medical Museum in Springfield as outlined

in its report. Because of the fact that some \$85,000 of ISMS funds is involved as the pro rata share in the restoration of the building, and some \$65,000 for the creation of displays and exhibits, this report must be considered together with the material presented by the Finance Committee. The House commended the members of the Committee for their efforts and adopted the report they presented.

The Committee on Benevolence has an annual deficit of from \$4,000 to \$7,000 each year. Voluntary contributions have provided a surplus this year and continue to assist the Committee materially. The work of the Woman's Auxiliary in this field has been outstanding through the years and is sincerely appreciated. The dues structure adopted by the House will contribute additional capital for this committee, which eventually may be able to provide for its recipients through a small allotment from the dues and income from investments.

The Committee on Impartial Medical Testimony has complex and interesting problems. The House complimented the committee for its work, and felt that significant progress has been made.

The majority of the work of the House in this committee report naturally was concerned with various phases of the legislative problems faced by medicine. The record of this committee and the Committee on Public Affairs was outstanding, and received the appreciation of the members of the House of Delegates. Some of these problems will be outlined individually as a result of action taken by the House on resolutions presented.

The Committee on Narcotics and Hazardous Substances faces an acute and important problem today. New legislation has been passed dealing with narcotics and more is expected. The members of the profession were asked to cooperate fully with this committee and to keep informed of activities in which the committee participates.

The Laboratory Evaluation Committee has worked in the field of legislation also. Dr. Hartney, chairman of the committee, has been appointed by the Governor as secretary of the Legislative Commission on Laboratories. He is to be complimented and also congratulated on his interest and success in this important field.

The St. Clair County Medical Society introduced a resolution reaffirming the Bauer resolution adopted by the AMA House of Delegates in 1961, and "disapproving" of participation under any governmental program to provide physicians' services to those 65 and over regardless of need. This resolution, and Resolution #40 from Madison County, similar in nature, were considered together and provoked animated discussion from the floor. Legal counsel was requested, and the resolutions were TABLED. The AMA is considering this problem and it is hoped that a detailed report will be available at the New York meeting in June, and

the opinion of the AMA legal staff expressed at that time.

The House approved an amended resolution which ruled that no officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name AS AN OFFICER OR MEMBER OF THE BOARD, to be used in lists endorsing candidates for public office. Naturally his right to this privilege as an individual was not involved.

The House approved a resolution urging the Senate Finance Committee to remove compulsory social security coverage for physicians from HR 6675; it also approved a resolution requesting opposition to the Douglas amendment to HR 6675, which would classify pathology, radiology, anesthesiology and psychiatry as hospital services and not "the private practice of medicine."

MISCELLANEOUS BUSINESS

The House endorsed the report of the special Committee to Study the Policy of the United States Chamber of Commerce, requesting this body to reconsider its stand in support of the extension of social security to all non-covered categories, including physicians.

The work of the Illinois delegates and alternate delegates to the AMA House was commended and the attention of the House called to the concentrated efforts expended, and the growing success experienced by the delegation.

The House approved bi-annual review of com-

mittee structure by the Committee to Study Committees of the Board, congratulated the Policy Committee for the Policy Manual included in the packet for members of the House. The House recommended that the Manual be made available to the ISMS membership and that suggested changes and recommendations relative to existing policy be submitted for action at the May 1966 meeting. The recommendation that the Policy Committee sit as a reference committee was referred to the Constitution and Bylaws Committee for a ruling.

The report of the President of the Woman's Auxiliary received the commendations of the House and its sincere appreciation for efforts expended in the many areas in which the ladies provide their husbands outstanding assistance and cooperation.

The House hoped that the Illinois Association of the Professions would continue to grow and become more and more active in the areas concerned.

The question of polling those members who also belong to AMA was considered under a resolution dealing with this subject. The AMA House of Delegates has gone on record repeatedly as being opposed to national polls. Its decision is based upon the fact that the AMA House of Delegates, through the democratic process of election, already represents the majority of physicians in this country, and its vote reflects national opinion.

ACTION ON RESOLUTIONS

1965 HOUSE OF DELEGATES

NO.	ACTION	SUBJECT	REF. COM.
65M-1	Montgomery County Medical Society: Drug Manual	Econ. & Ins.	NOT adopted
65M-2	St. Clair County Medical Society: Drug Manual	Econ. & Ins.	NOT adopted
65M-3	Christian County Medical Society: Drug Manual	Econ. & Ins.	NOT adopted
65M-4	Winnebago County Medical Society: Drug Manual	Econ. & Ins.	NOT adopted
65M-5	Kendall County Medical Society: The Liberty Amendment	Legis. & Pub. Affairs	NOT adopted
65M-6	DuPage County Medical Society: Shortage of General Practitioners	Pub. & Scien. Services	Substitute Resolution
65M-7	DuPage County Medical Society: Rotating Internships	Pub. & Scien. Services	Substitute Resolution
65M-8	DuPage County Medical Society: Medical Education for Physicians in Practice and Physicians in Research	Pub. & Scien. Services	Substitute Resolution
65M-9	DuPage County Medical Society: Preceptor Visits by Students	Pub. & Scien. Services	Substitute Resolution
65M-10	Champaign County Medical Society: Upgrading of Obstetrical Fees in IDPA Cases	Econ. & Ins.	NO action
65M-11	Champaign County Medical Society: Physician's Right to Prescribe Drugs of Choice	Econ. & Ins.	NOT adopted
65M-12	Kendall County Medical Society: Fixed Fees	Econ. & Ins.	NOT adopted
65M-13	George W. Holmes for Committee on Tuberculosis: Recommendation and Task Force on Tuberculosis Control	Pub. & Scien. Services	ADOPTED

NO.	ACTION	SUBJECT	REF. COM.
65M-14	Winnebago County Medical Society: Legalized Abortion	Pub. & Scien. Services	Referred to Board
65M-15	McLean County Medical Society: Endorsement of Legislation by the House of Delegates	Legis. & Pub. Affairs	NOT adopted
65M-16	McLean County Medical Society: Compulsory Area Wide Planning of Hospitals Under State Control	Legis. & Pub. Affairs	NOT adopted
65M-17	Will-Grundy County Medical Society: Polling AMA Members for Opinions	Ref. Comm. on Misc. Business	NOT adopted
65M-18	Committee on Archives: \$150,000 for Medical Historical Museum; \$50,000 from allocation of \$1 per year per member of ISMS dues	Ref. Comm. on Legis. & Pub. Affairs	Referred to Finance Com.
65M-19	Tazewell County Medical Society: Compulsory Area-Wide Planning of Hospitals Under State Control	Legis. & Pub. Affairs	NOT adopted
65M-20	Tazewell County Medical Society: Indorsement of Legislation by the House of Delegates	Legis. & Pub. Affairs	NOT adopted
65M-21	DuPage County Medical Society: Fee Schedule for Public Assistance Recipients	Econ. & Ins.	NO action
65M-22	Hancock County Medical Society: Drug Manual	Econ. & Ins.	NOT adopted
65M-23	Committee on Environmental Health: Intensification and Expansion of Activities in the Field of Air Pollution	Pub. & Scien. Services	APPROVED
65M-24	Macon County Medical Society: Drugs for Public Aid Recipients	Econ. & Ins.	NOT adopted
65M-25	Macon County Medical Society: Medical Fees for the Care of Public Assistance Recipients	Econ. & Ins.	ADOPTED
65M-26	Chicago Medical Society: The Need for and the Training of Additional General Practitioners	Pub. & Scien. Services	Substitute Resolution
65M-27	Chicago Medical Society: Need for Additional General Practitioners	Pub. & Scien. Services	Substitute Resolution
65M-28	Alexander and Pulaski Counties: Procedures of the Illinois Department of Public Aid	Econ. & Ins.	NOT adopted
65M-29	Chicago Medical Society: Study of Emergency Room Service	Econ. & Ins.	ADOPTED
65M-30	St. Clair County Medical Society: Disapproval of Participation Under HR 6675	Legis. & Pub. Affairs	Tabled
65M-31	Winnebago County Medical Society: Payment for Blood and Plasma in Major Medical Insurance	Econ. & Ins.	ADOPTED goes to AMA

NO.	ACTION	SUBJECT	REF. COM.
65M-32	Chicago Medical Society: Endorsement of Political Candidates	Legis. & Pub. Affairs	ADOPTED as Amended
65M-33	Chicago Medical Society: Additional Medical Students	Pub. & Scien. Services	Substitute Resolution
65M-34	Chicago Medical Society: Study of Intern-Resident Training Programs	Pub. & Scien. Services	Substitute Resolution
65M-35	Lake County Medical Society: Opposition to Douglas Amendment to HR 6675	Legis. & Pub. Affairs	ADOPTED
65M-36	North Shore Branch of CMS: Water Pollution	Pub. & Scien. Services	ADOPTED
65M-37	Henry-Stark County Medical Society: Supply of Physicians	Pub. & Scien. Services	Substitute Resolution
65M-38	Henry-Stark County Medical Society: The IDPA Drug Manual	Econ. & Ins.	NOT adopted
65M-39	Wayne County Medical Society: Coverage of Physicians under Social Security	Legis. & Pub. Affairs	ADOPTED as Amended
65M-40	Madison County Medical Society: Disapproval of Fixed Fees under HR 6675	Legis. & Pub. Affairs	Considered with Res. #30 which was Tabled

In special explanation of some of the actions outlined above, the following summary is presented:

Resolutions Nos. 1, 2, 3, 4, 11, 22, 24, 28, and 38 all pertained to the Drug Manual and were considered together by the Reference Committee on Economics and Insurance. They were NOT adopted.

Resolutions Nos. 10, 21 and 25 were considered together by the Reference Committee on Economics and Insurance, and dealt with fees for public aid patients. Resolution No. 25 was ADOPTED. (Resolutions Nos. 10 and 21 were covered in 25, so in these cases, NO ACTION was taken.)

Resolutions Nos. 6, 7, 8, 9, 26, 27, 33, 34, and 37 all dealt with the same basic problems of medical education, intern and residency training, etc., and the Reference Committee on Publications and Scientific Services considered them together, prepared a SUBSTITUTE RESOLUTION covering this material which was ADOPTED AS AMENDED.

All other actions were taken individually, and stand as presented.



Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES
OF THE ILLINOIS STATE MEDICAL SOCIETY

June, 1965

Highlights of 125th Annual Convention May 16-19

Dr. Montgomery Installed as ISMS President

In his inaugural address to the ISMS House of Delegates Wednesday, Dr. Burtis E. Montgomery said, "We must be permitted by the government, through our organizations, to collaborate with its departments on all matters affecting medical care and the administration of federal medical care programs."

In discussing Medicare, he asserted that physicians over the years have contributed thousands of free hours at the request of government agencies. "Now the federal government threatens to destroy this co-operation and establish a government monopoly of health care service which would ultimately lead to medical and political unrest similar to conditions in countries abroad," he said.

Dr. Sims and Officers Open Exhibits

Dr. Edward A. Piszczek, ISMS president, and Dr. SIMS, corporate symbol of the Illinois State Medical Society, officially opened the convention exhibits with a ribbon cutting ceremony Monday morning. There were a total of 63 technical exhibits and 32 scientific exhibits.



THANKING DELEGATES for opportunity to serve as Society's goodwill ambassador over the past year, "Dr. SIMS" voices fervent hope to continue representing ISMS on radio, television, outdoor billboards and in the newspapers. After introduction by ISMS Trustee Dr. Frank J. Jirka, Jr., right, Dr. SIMS was given surprise "birthday party" to celebrate one year as ISMS representative.

West Suburban Hospital was the winner of a gold medal for the educational value of its scientific exhibit, "Practical Photo-scanning," and the University of Minnesota Medical School was given a gold medal for the most original scientific exhibit, "Aminocaproic Acid: Investigations from a University Medical School."

Dr. Annis Calls Medicare Political Swindle

Hailing the advances in medical science in the past 25 years as greater than those of the previous 2,500 years, Dr. Edward A. Annis, immediate past president of the American Medical Association, told a capacity audience at the ISMS Public Affairs dinner Monday that the profession had been remiss in not helping the public to understand the cost of this progress. He said that people do not appreciate the fact that organized medicine is directly responsible for the great strides that have been made in America compared to lesser progress in parts of the world where medicine is divided or poorly organized. He blamed

this lack of understanding for the development of Medicare, which he called a "political swindle."

"Political medicine is just as bad as quackery and it's about time we doctors put the spotlight on the political fraud the Administration is trying to sell the American public," Dr. Annis said.

Accusing the Johnson administration of playing politics with people's health, Dr. Annis linked the National Senior Citizens Council with Walter Reuther's labor lobby and reported that several congressmen have received "threats that appropriations would be cut off in their areas" if they voted against Medicare.

Seven Receive Awards for Public Affairs Participation

Six physicians and a physician's wife were given awards at the Public Affairs dinner for their "distinguished participation in public affairs." Dr. John Newkirk, chairman of the ISMS Committee on Public Affairs, presented awards to:

Dr. Paul B. Boswell, state representative from Chicago and member of the board of directors of the Illinois Council for Mentally Retarded Children; Dr. William A. Moore, state representative and former city commissioner from Olney; Dr. Andrew Toman, Cook County Coronor and delegate to the 1964 Democratic National Convention; Dr. Joseph W. Cannon, alternate delegate to the 1964 Republican National Convention; Dr. Chester T. Podgorski, Chicago precinct captain and Republican candidate for U. S. Congress; Dr. James A. Weatherly, Republican candidate for University of Illinois trustee, and Mrs. Edith Scruggs, Chicago precinct captain and alternate delegate to the 1964 Republican National Convention.

DOCTOR'S PLACE IN LITERATURE TOLD BY CAMP LECTURER

Describing "The Satirists' War on Medicine," Dr. Edward Rosenheim, Jr., Camp Memorial Lecturer, put the finger on satirical writers for making the public fearful, resentful and "constantly suspicious that doctors are unholy and charge too much."

He traced their literary "potshots" at the medical profession to basic human fear of the unknown with which non-professionally trained individuals frequently regard professionals. "This fear is heightened by the fact that a doctor's training gives him power over another man's well-being and over life itself," Dr. Rosenheim said.

He listed as other factors working against the doctor's image the suspicion of being overcharged because at times there is little to show for money spent on medical care; technical language that the layman doesn't understand and therefore regards with suspicion, and diagnostic procedures which seem strange, indelicate and of no practical consequence to the untrained mind.

Throughout history physicians have been attacked as "complacent, pompous and totally inhuman," the speaker pointed out, and the image has only slightly improved lately with the rise of "physician idols on television."

Dr. Piszczek: Hold Principles Inviolable

In his annual address to the Illinois State Medical Society, President Edward A. Piszczek, M.D., warned ISMS members to "remain unified and reject the aim of government to divide our house by classifying some physician's services as hospital services." He said that medical judgments must transcend political judgments and that "it is the sole responsibility of physicians to guide the internal hospital medical staff and we must not allow this responsibility to be

delegated to an outside agency or to non-physician personnel."

Dr. Piszczek further stated that "if payment for medical care for all elderly, regardless of need, becomes a responsibility of the federal government, there is no justification for physicians to treat such patients for less than their customary fee or at no fee." He advised that "fees must be determined in the market place on the basis of what is customary as established by individual practitioners and their patients."

Medical Schools of Illinois Receive \$195,000

Contributions totaling more than \$195,000 from the American Medical Association's Education and Research Foundation were presented to Chicago's five medical schools during the opening session of the House of Delegates. Presentation was made by Dr. Carl E. Clark, chairman of the Finance Committee, and accepted by Loyola's Dean John F. Sheehan for:

University of Illinois College of Medicine, \$53,017; Northwestern University School of Medicine, \$46,179; Stritch School of Medicine, Loyola University, \$38,372; Chicago Medical School, \$34,493, and the University of Chicago School of Medicine, \$22,948. The checks represent contributions from private physicians and their families throughout the country and include a \$20 annual contribution from each ISMS member. Illinois physicians have provided \$2 million since the AMA-ERF was established in 1951.

BILLBOARD PROGRAM GIVEN AWARD

The first ISMS Outdoor Advertising Public Service Award was presented to the Foster and Kleiser Co. for its efforts in implementing a unique 1964-65 preventive medicine billboard campaign — a first in public health education. F & K vice president Larry Bulling and art director George Holtane accepted the award Sunday at the House of Delegates meeting.

SAMA President Thanks ISMS

David Kindig, president of the University of Illinois chapter, Student American Medical Association, expressed the gratitude of the five Chicago SAMA chapters for the assistance ISMS has given them during the past year. In addressing the House of Delegates Sunday, he cited the recent ISMS-CMS-sponsored SAMA conference which provided students from different schools with an opportunity to meet socially and gain insight into the relationship between the doctor and society.

MRS. SCRIVNER REPORTS ON AUXILIARY ACTIVITIES

Mrs. Willard Scrivner, president of the Woman's Auxiliary to ISMS, told the House of Delegates Sunday that a new auxiliary had been organized in Morgan County during the past year, that McHenry County is ready for reactivation, and that Jackson County has excellent possibilities for organizing an auxiliary in the near future. She said that there are now 41 county auxiliaries in Illinois with 1,785 members. It has been suggested that dual membership be encouraged. This means that when a physician joins a county medical society, his wife automatically becomes a member of the county auxiliary. Further, it was suggested that both dues be collected from the husband.

PROBLEMS OF THE CLEFT PALATE AND CLEFT LIP CHILD

Casper M. Epstein, M.D., D.D.S./chicago

THE PHYSICAL PROBLEMS INVOLVED in the successful care and treatment of cleft lip and cleft palate patients can be so absorbing that neglect or oversight of one very important aspect may decide the difference between success or failure for the rest of the rehabilitation program.

The author has been concerned for many years with patients primarily as individuals, as human beings who live and must live with other people in this world. They are people with emotions, with feelings, with a heart, and with a brain. Much harm has come in the past through failure or neglect to recognize the psychological and emotional aspect associated with these deformities or disfigurements. Too many people have so often been unaware of the serious handicap imposed upon these patients not merely by their physical appearances, but more especially by the emotional and mental reactions which affect their personalities. It is fully recognizable that in most cases of cleft lip, a telltale defect or residuum remains, even though the results are what has been considered, knowing the original condition, a most acceptable outcome. Nonetheless, the patient who lives day in and day out with this problem is cognizant when in company with others that there is a difference between them. One of the fundamental differences associated with facial deformities is the impression imparted to others by virtue of appearance. Society, even in a child's world, has a very definite concept as to what is normally ac-

ceptable, and any deviation from this fixed concept may be the cause of a negative reaction. In our society today, whether it be amongst children or adults, social distinction is based upon many factors, including physical normality and attractiveness. Before further discussion of the psychological and emotional reactions created in these children by virtue of their physical facial appearance, it would be well to examine the background of the problem, which starts with the parents.

A congenital defect as traumatic as a cleft lip and/or cleft palate frequently arouses in parents extreme feelings of fear, guilt, and even rejection, as well as creating numerous misconceptions as to why this happened to their child, and also the possibilities for correction. They may, and not infrequently do, blame themselves for the birth of a child with such a deformity. The emotional factors and feelings in parents, in turn, can be transferred to the child very early and quite completely, and can seriously affect the parents' ability to grasp the many problems associated with the defect of the child—and so to deal properly and successfully with them. If the parents are competent to understand the problem and to prepare the child for it, the chances of psychological damage become less, although certainly not completely eradicated. And it becomes most incumbent upon us to explain in detail to the parents the problems involved, and what needs to be done. They must be told immediately that they themselves are not at fault and must not assume the blame or a feeling of guilt. A calm, assuring, and understanding discussion and explanation can very well be the beginning of therapy for the child.

Children are aware of their difficulties

Read at the Session of Maxillofacial Surgery at the Meeting of the American Medical Association in San Francisco, California, June 24, 1964.

long before adults realize. A case is recalled of a mother relating that her child who was born with a cleft lip which had not been operated upon at birth or shortly thereafter, was allowed, for one reason or another, to remain unoperated upon until approximately 2½ to 3 years of age. The parents applied the ostrich technique by telling themselves that the deformity was not so severe and that others had worse problems than their child. However, the one thing that brought home to them the plight of their child was that whenever this child saw a mirror she would finger her lips—looking into the mirror to see the difference between a cleft lip and what a lip would look like were it one complete unit. It took this little baby to awaken in the parents the need that something should be done. Case #2—A child, 3½ years of age, had a repair, but unfortunately it was not a very good repair. The child was one of several in the family, but the only one with this deformity, and strangely enough this 3½ year old child became quite cognizant that he was different from the other children in the family. He walked around with, or had very close at hand, a toy teddy bear which he placed in front of his face whenever a stranger came into the house.

As the child grows older and comes in contact with other children, he is made more aware of his problems. Children are notoriously observant of the unusual, and are cruel. They have no inhibitions. A great deal of undue attention is invariably directed to any cosmetic abnormality possessed by a playmate. There is no attempt on the part of a child to conceal his curiosity or to refrain from ridiculing his afflicted companions. Whether his intentions are malicious or sympathetic, he will be openly frank in his discussions and opinions. L. M. E., age 8, told of the many teasing and untruthful stories the boys in school told about her—relating to sex.

Speech difficulties in children also create problems of fear and hate, often with a desire on the child's part for vengeance against their tormentors. Such children become withdrawn, shy, retiring, introverted, and introspective. Parents are so often

thrilled that their child can be understood that they sometimes make no attempt to improve their speech. Case #3—This child did not have a lip defect, only a palate defect. In the usual course of time the defect was very successfully repaired and the child was sent to a speech therapist and did obtain a very acceptable result, although there was a very definite residuum. The child was intelligent, but was very withdrawn and became quite an introvert. To hide some of her problems she ate at frequent intervals and became quite obese. One day the mother was asked if her daughter had any problems in school and the answer came back immediately, "Oh, no, she has many friends and she has no problems at all. The children never remark about her speech." As is the author's custom, the mother was asked to leave the room and he spoke to the child alone. The topics of conversation were varied, and then gradually came the speech question. "Do you have many friends?" she was asked. She looked down and said, "I think I do." "Do any of the kids in school say anything to you about the way you talk?" As she looked up, tears welled into her eyes, and she said, "A lot of them ask me what is the matter with the way I talk." When the mother was called in and the questioning was repeated, she was shocked because her child had never before spoken to her about it.

This problem is recited because it is not new or unique, but it is also not uncommon. It becomes incumbent, therefore, upon those who take care of children to recognize these factors and help toward their correction. These children are tormented. They are tormented by other children and they are tormented by their own feelings. The society of children is a very unique one. Their attitudes concerning normality and abnormality are as significant and important as any medical considerations of health or disease. A note of permanence is not infrequently added to these childhood stigmas by dubbing the deformed child with a derogatory nickname which refers to his defect. One patient recently stated that the kids in school called him "lippy."

Many of these children develop a feeling

of inferiority and a sense of shame, and these mental factors develop much earlier than is generally realized. As the child enters school, or just before he enters school, when he comes in contact with other children in a larger group, the feeling of inferiority can become a very serious problem. Although the parents have attempted to shield and protect them up to this time, these children become aware at this particular period of their life of the difference between them and other children, and without the proper preparation in meeting other children and getting along with them, they are not able to acquire the intimate companionship that is necessary and for which they long, and which is enjoyed by their playmates. Unless an attempt to correct these problems is made at an early age, the child becomes increasingly more sensitive as he grows and matures. Terry, age 7, one day asked: "Doctor, why do I have to have a lip like this?"

When they reach the age of adolescence, they have by this time established within themselves, without even knowing it, a rather pessimistic philosophy of life mixed with all sorts of peculiar personality traits. Most of these children who have developed this feeling of inferiority and sense of shame grow up with a desire for companionship. As all children, they want to be liked. They want to belong. They want to be accepted for what they really are and not be judged by virtue of the fact that they have a disfigurement or deformity. They cannot hide their problems, but because of their deformity they may be regarded as inferiors and assigned in any large group to a status lower than their companions. As much as they do not want to be with children who make fun of them, they still want a relationship with other children. So to satisfy this craving, they seek children of a much younger age group. It is not uncommon for a ten or twelve year old child to play with a four or five year old child. This is not healthy from a standpoint of development. Case #4 is that of a child born with a severe bilateral complete defect. The mother had won several beauty contests and the father was considered a

collar-ad type of person. They were both very intelligent and understanding people. When their child, an only child (and they refused to have more after this birth) was playing with a child half her age, her mother remarked to her, "Honey, why don't you play with so-and-so?" (who, incidentally, was closer to her own age); the child turned to her mother with a bit of hatred in her face and said, "How would you like to have what I've got?"

Personality development in children depends upon *two* fundamental drives. One is for *self-expression*, i.e., the ability and desire to express their thoughts and feelings in a way that is pleasant, acceptable to others, and easily understood. The other drive is emotional—to live and perform and act as other people their age do; in other words, to conform with the accepted standards in which they live. When these two factors are successful, a pleasing personality develops. The child with a deformity usually has every mental and physical faculty for self-expression possessed by other children, but because of his deformity he does not have, as a rule, the personal association with other children which is so necessary for such expression because others avoid him or he withdraws into himself in order to avoid being hurt. Equally important in the development of a child's personality is a child's acquisition of popularity. Before a handicapped child can gain recognition from his group, he must first overcome their feelings about his deformity. Fortunately, there are many children who can do this. Unfortunately, there are some children who are inclined to resign to their problems and make no effort to become one of the group. They become resentful toward their obstacles and mistreatment, and withdraw into a shell and become very lonely. Loneliness is a sickness of the soul that no amount of drugs nor any surgery can cure. A bit of compassion and understanding for these children is extremely important. They are human beings and must be treated as human beings. "Wisdom is the most important thing, therefore get wisdom, but with all thy wisdom, get understanding." When these children fail to ad-

vance and mature, they become bitter and place the cause for their failures, either inwardly or openly, on all manner of circumstances and people and they become quite antisocial. Case #5. J. S. first consulted the author when he was 17 years of age. His palate had been repaired with much scarring. His lip was repaired but there was room for a great deal of improvement. His mother died when he was a baby and his father remarried. Other children came along and J. S. became an unwanted member of the family. When he was old enough he ran away from home and was quite embittered. He had seen several physicians regarding corrective work on his lip. None had suggested speech therapy. When first seen, he was more than resentful towards everybody, but particularly bitter towards his father. He blamed all his woes on his father because he said his father had syphilis and that was the reason for his mother's death, and for his own difficulties.

Behavior difficulties in children are often misinterpreted by well-meaning parents who blame these difficulties on a lack of the child's companionship with children of their own age, the fact that they have had frequent or serious illnesses, and also the fact that they may have difficult living conditions. There are many children who refuse to go to school because their playmates make fun of their appearance or of the way they talk. When they are forced by their parents to go to school, not infrequently they become truants, or they may come home from school after dark in order to avoid other children's jibes and teasing. They may develop a feeling of insecurity and inadequacy. Three things may happen to these children. The pressures may be too great for them to fight back and so they become afraid and give in, accepting non-expression as a part of the price they pay. Secondly, they may become a very outgoing individual to satisfy or compensate for the hurt they feel inside. Third, under more fortunate circumstances they may substitute their suppressed modes of self-expression with other outgoing activities such as athletics, music, art, etc.

As a child reaches adolescence or his

early teens, the problems of his social relationship to other people or his classmates become more marked because it is at this time that school functions are held for these children and companionship with the opposite sex is difficult for them to obtain. This period of their life is particularly difficult. When these children find the difficulties in attending the social affairs of school in their teen-age years, they become more withdrawn than ever. Case #6. F. S., who has since grown into manhood, had a very severe bilateral complete defect. He was first seen by the author at the age of seven years and by that time much of the work had been done. He was also born with a deformity of his hands and an absence of some of his fingers. When seen recently, he held a position as a bookkeeper in a large organization. His place of employment was approximately three or four miles from his home, but F. S. related that he used to walk to work in the morning and home at night because he did not like to have adults staring at him on the bus. He said, "I don't mind children looking at me, Doctor, because they don't know any better, but when grown-up people stare at me as though I am somebody most peculiar, it becomes a little disconcerting and uncomfortable. I would rather walk than have this happen to me."

Case #7. D. L. was born with an absence of her premaxilla and a very wide defect in the palate and lip. She had also had an absence of a part of her nose. Much work had been done upon her and she led a rather unfortunate life inasmuch as the trauma that she experienced was tremendous. Yet, she had the proper handling and grew up with a sense of self-dependence and reliability. She realized that she would have to take care of herself for the rest of her life, so she trained as an infants' nurse and went to work in the nursery of a large hospital. There were several changes of employment for her and when she sought a new position after having been out of work for several months because of illness, she was told that there was no place available for her because she would have to work in some place where even the parents couldn't

see her. It is obvious then, that many of the problems of adolescence and adulthood stem from experiences the child encounters during his growing up and formative years as well as adult years.

Strangely enough, many of these unfortunate experiences occur in the patient's own home. Parents of these children usually state that they treat the child with cleft palate and/or cleft lip no differently than they treat the other children in the family, and yet when a very close and scrutinizing examination of the situation is made, there is not infrequently found in a

number of cases a tendency to favor the child without any defect. On the other hand, there may be also quite the reverse. The feeling of guilt by the parent may be so great that they are wont to shower much attention upon the child with the deformity.

And so it is seen that surgical correction, even with a very good cosmetic result, is not the end of care for these patients. They need friendly understanding and even sympathetic understanding, but they do not need nor do they want sympathy. They need friends, they need confidence, and they need guidance as they grow up.

HERBS AND QUACKERY

We were informed in the village of Boa Vista that it is a common practice in those modern Brazilian villages that are large enough to support a drug store, for the village druggist to prescribe and administer an injection of penicillin, or other injectable medication, upon the request of the patient. The cost is a few cruzeiros if the patient supplies the vial of medication and a few more cruzeiros if the druggist supplies both the medicine, syringe and needle. Many cases of infectious hepatitis have resulted from this widespread practice due to inadequate sterilization of the syringe and needle after use on an unrecognized carrier patient. This misjudgment compares favorably with that of our tattoo artists of North America who are guilty of transmitting the same disease in somewhat the same way.

The numbers of herb drugs that have been investigated by primitive and modern man are indeed countless. Some have developed into lifesaving miracle drugs, and countless others have become fascinating legends. Still others are no more useful than are many of the nostrums that are being accepted by the North American public today such as the worthless "Ambrosia of the Gods," unneeded "food supplements" and "Royal Jelly." The story of modern American quackery is no less fantastic than is the history of herb medicines and certainly much less benefit shall come of the former. *The Journal of the Kansas Medical Society, September, 1964.*

THE VIEW BOX

Lecn Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

This 60-year-old woman had a routine chest film. The requisition contained no further information.

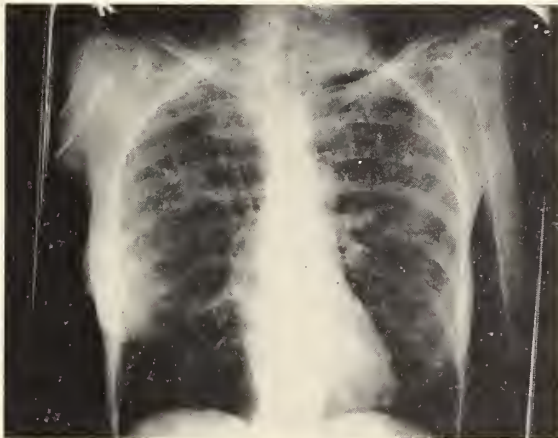


Figure 1.

What is your diagnosis?

1. Syringomyelia
2. Hyperparathyroidism
3. Charcot Joints
4. Rheumatoid Arthritis

(Answer on next page)



Figure 2.



Figure 3.

Diagnosis: Rheumatoid Arthritis

The radiographic findings in the hands have received the maximum amount of attention in the literature. However, changes in other joints and bony structures are frequently present.

The chief lesion is a chronic synovitis, both of tendon sheaths and joints, often with massive synovial proliferation. Granulation tissue forms on the articular surfaces and is associated with gradual destruction of articular cartilage and adjacent bone.

The characteristic changes in the hands (Figs. 2 and 3) are fusiform, soft-tissue swelling in the interphalangeal joints (soft-tissue thickening in the wrist adjacent to the ulnar styloid may be noted), narrowing of interosseous joint spaces, malalignment and subluxation of joints (ulnar deviation and volar subluxation of metacarpophalangeal joints), bone erosions which occur at joint margins, and bony ankylosis (Fig. 4) are the most important findings.

Similarly these changes are noted in the shoulder joints in our patient (Fig. 1), which would suggest the diagnosis of rheumatoid arthritis. In addition, our patient



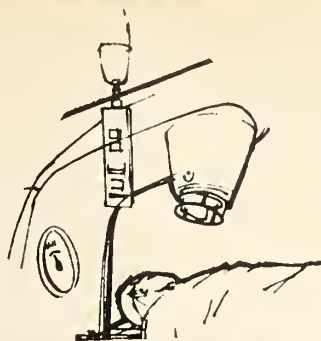
Figure 4.

demonstrated subperiosteal resorption of the distal clavicles (also seen in hyperparathyroidism but without the joint changes). Another interesting finding is erosion of the superior aspect of the posterior 3rd right rib, which has been reported in rheumatoid arthritis but with no explanation as to etiology.

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Medical Progress



HARVEY KRAVITZ M.D./progress editor

CLINICAL SIGNIFICANCE OF SPECIFIC FINDINGS IN ELECTRO- ENCEPHALOGRAPHY

PART 2 OF A
4 PART SERIES

F. A. Gibbs, M.D., and E. L. Gibbs/chicago

Normal

A normal electroencephalogram is presumptive but not positive evidence of normality. If there is no evidence to the contrary, it suggests that there is no acute or progressive damage to the outer convexity of the cerebral hemispheres, no highly active epileptic process, and no widespread disturbance of that portion of neuronal metabolism that underlies voltage production in the brain.

A normal electroencephalogram means different things at different ages. During the first year of life it is more likely to be normal than at any other time regardless of the diagnosis or symptomatology (hypsarhythmia and infantile spasms excepted). This is because in early life the electrical activity of the brain is relatively undeveloped and abnormal as well as normal activity is feebly expressed. Nevertheless, spike discharges and slow wave foci do occur in infants, and if present are clearly abnormal.

Severe structural damage is often unassociated with electroencephalographic abnormality. Slowly developing lesions, atrophic processes, meningiomas, subdural

hematomas and demyelinating diseases may produce little or no electroencephalographic abnormality. Patients with hemiplegia from an intracerebral hemorrhage frequently have a normal waking electroencephalogram. In approximately one-quarter of all cases of deep cerebral and subtentorial tumor the electroencephalogram is normal. Thus, a normal electroencephalogram cannot be accepted as evidence of "no brain damage."

In spite of these limitations, when properly evaluated, the presumptive evidence provided by a normal waking electroencephalogram is often of great practical value, for (when there is no evidence to the contrary) a normal electroencephalogram gives assurance that the accessible cortex has not been invaded by an acute infectious process, is not the site of a recent contusion, laceration, hemorrhage, thrombosis, or embolism, and is not being injured by a rapidly growing neoplasm.

Only about one-third of the cerebrum can be viewed by nonsurgical electroencephalography. If abnormalities are confined to subtentorial structures, to the central gray masses, to buried cortex, to deep layers of

the cortex, or to white matter, the electroencephalogram is normal. Even when situated in the accessible cortex a destructive injury may be invisible, if it is unassociated with irritation, if it is small, or if it involves homologous areas in the two hemispheres.

Some pathological processes involving the cortex produce severe abnormalities during the acute stage, but in the chronic stage abnormality may subside and the electroencephalogram may become normal even though a structural lesion is still present and symptoms persist. This commonly occurs in postencephalitic behavior disorder and also in infantile spasms with hypsarrhythmia.

Abnormal

The incidence of various types of abnormality in 38,082 consecutive cases referred for electroencephalographic study and in 3,476 control subjects, is shown in Tables 1 and 2. As would be expected, from what has been said in the preceding section, most abnormalities are less likely to show in the first and second year than later. In the third to twelfth year the electroencephalogram becomes hypersensitized, but after the twelfth year it accords closely with the degree of clinical disturbance.

Age is a major determinant of the amount and type of abnormality that appears (Fig. 1). Follow-up studies and serial electroencephalograms indicate that the disorders which underlie epilepsy tend to clear up with increasing age. If a focal epileptic process persists, it tends to migrate from the occipital lobe of the infant, to the mid-temporal area of the school child, to the diencephalon of the adolescent and to the anterior temporal area of the adult. Of course destructive injuries and structural damage remain essentially fixed, but not all forms of brain damage are permanent. Epilepsy is based on types of disorder that are variable and reversible. Seizure discharges can and often do clear up over a period of months or years. The same holds true for other types of electroencephalographic abnormality. Recovery is the rule from various types of minor brain injury that manifest themselves electroencephalographically

but that are unassociated with gross or histological evidence of brain damage.

Very High Voltage Activity

High voltage activity in the normal frequency range is encountered in some persons with hydrocephalus and also among some patients with nonspecific types of mental retardation. In the former this is presumably due to the thinness of the skull and the resultant close approximation of the scalp electrodes to the brain. (Voltages obtained directly from the brain at operation are approximately three times as great as those recorded from the scalp.) A localized area of increased voltage is commonly present over a skull defect or a tantalum plate.

Retained or Persistent Alpha Activity

Occasionally cases are encountered where what appears to be alpha activity persists in one area during sleep but drops out in all others. However, this persistent alpha activity usually has a slightly slower frequency than the patient's normal alpha rhythm. It is in the temporal area that alpha activity most usually persists. In some cases no evidence of a lesion is present, but in others the persisting alpha activity lies in or near the site of a traumatic injury, a surgical lesion, or some other type of structural damage. The finding of retained alpha activity is presumptive but not positive evidence of structural damage and it is a fairly reliable localizing sign in cases where other evidence points to brain damage.

Extreme Spindles

Extreme spindles are an abnormal sleep pattern usually seen in young children and very rarely in adults (Fig. 2). They resemble the normal spindles of sleep except that they are more diffuse, of higher voltage (200-400 microvolts), and more-or-less continuous. The frequency varies from case to case in the range of 6 to 18 cycles per second. This abnormality is almost never encountered in normal control subjects; it does not correlate with epilepsy but does correlate with mental retardation.⁶

Generalized or Symmetrically Reduced Voltage

Such great individual differences occur in

the amplitude of the normal electroencephalogram that generalized, bilateral, or symmetrical reduction in voltage cannot be identified positively unless it is extreme (i.e., average voltage below 5 microvolts) or unless, perchance, a previous recording is available. Extremely low voltage recordings are found after trauma, after surgery, and after severe damage from various causes. Reduction in voltage over both hemispheres in both the waking and sleep states is more-or-less characteristic of microcephaly and of functional decortication from hypoxia, hypoglycemia, or trauma. It is also seen in some cases of undifferentiated mental retardation. Low voltage waking activity is common in Huntington's chorea.

Asymmetry, Localized or Lateralized Reduction or Suppression of Voltage

A localized moderate decrease in voltage production is a mild depressive* reaction to injury. It is nonspecific as regards etiology. Though common in cases of subdural hematoma, it does not create a presumption that a hematoma is present.⁷

Extreme lateralized reduction in amplitude occurs with severe cortical damage or with destruction of the cortex, as for example in porencephaly, hemiatrophy, and hemispherectomy.⁸

A marked difference in voltage of sleep patterns in the two hemispheres indicates damage on the side of the lower voltage. It is a reliable sign of lateralized injury particularly when the amplitude of sleep patterns (biparietal humps and 14 per second spindles) is reduced. Such asymmetry is common in the hemiplegic form of cerebral palsy and in cases of cerebral vascular accident.⁹

Asynchrony

Up to the age of 8 months the predominantly central 14 per second spindles of sleep are asynchronous.¹⁰ However, by one year of age they become fairly synchronous. Twelve per second frontal spindles remain somewhat asynchronous throughout life.

*Depressed function, not a depression in the psychiatric sense.

Biparietal humps are a normally synchronous sleep pattern at all ages.

A lack of the normal degree of synchrony between sleep patterns in the two hemispheres is characteristic of hydrocephalus.¹¹ This abnormality is seen in some cases where a deep mid-line tumor is present, also in some children with the paraplegic form of cerebral palsy,¹² and in other conditions where there is reason to believe that the connections between the left and right thalamus have been damaged.

Frontal slow activity in deep sleep is normally synchronous, but 18 months after frontal lobotomy it becomes asynchronous,¹³ presumably due to trans-synaptic retrograde degeneration of commissures connecting the left and right thalamus.

Delta, Theta, Alpha, and Beta Waves

The Greek letters commonly assigned to waves of various frequencies are as follows: delta indicates frequencies of less than 4 cycles per second; theta indicates waves between 4 and 7 cycles per second; alpha between 8 and 13 per second; and beta, higher than 13 cycles per second.¹⁴ More informative than these Greek letters is a statement of the frequency and wave form and a characterization of the activity as normal or abnormal, fast or slow, taking into account the subject's age and his state of wakefulness or somnolence.

Generalized Fast Activity

An excessive voltage or unusual amount of activity above 13 cycles per second, is classified as *abnormally fast*. This abnormality suggests an irritative response to some type of injury; it is epileptiform, but not truly epileptic. Although it is twice as common in the awake recording of persons with seizures as in normal control subjects, it does not create a strong presumption that seizures are occurring or will occur. Many drugs and conditions that produce sleep or a sleep-like state cause an increase in fast activity. Amobarbital (Amytal), meprobamate (Miltown or Equanil), chlorthalidoxepoxide (Librium), and diazepam (Valium) are particularly likely to do so.

Fast activity is graded as *slightly abnormal fast* (F-1), *very abnormal fast*

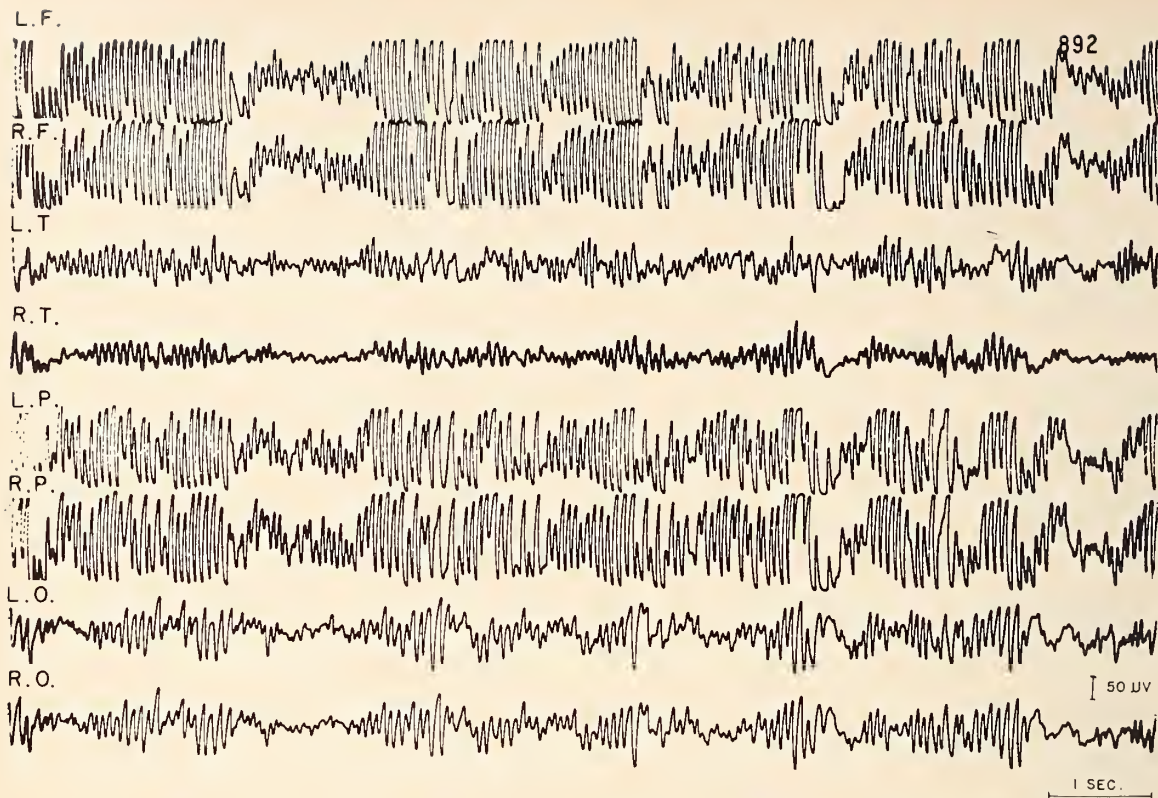


FIGURE 2. Extreme 14-16 per second spindles, maximal in the frontal and parietal areas. The time and voltage calibrations shown in this figure are the same as in all other figures.

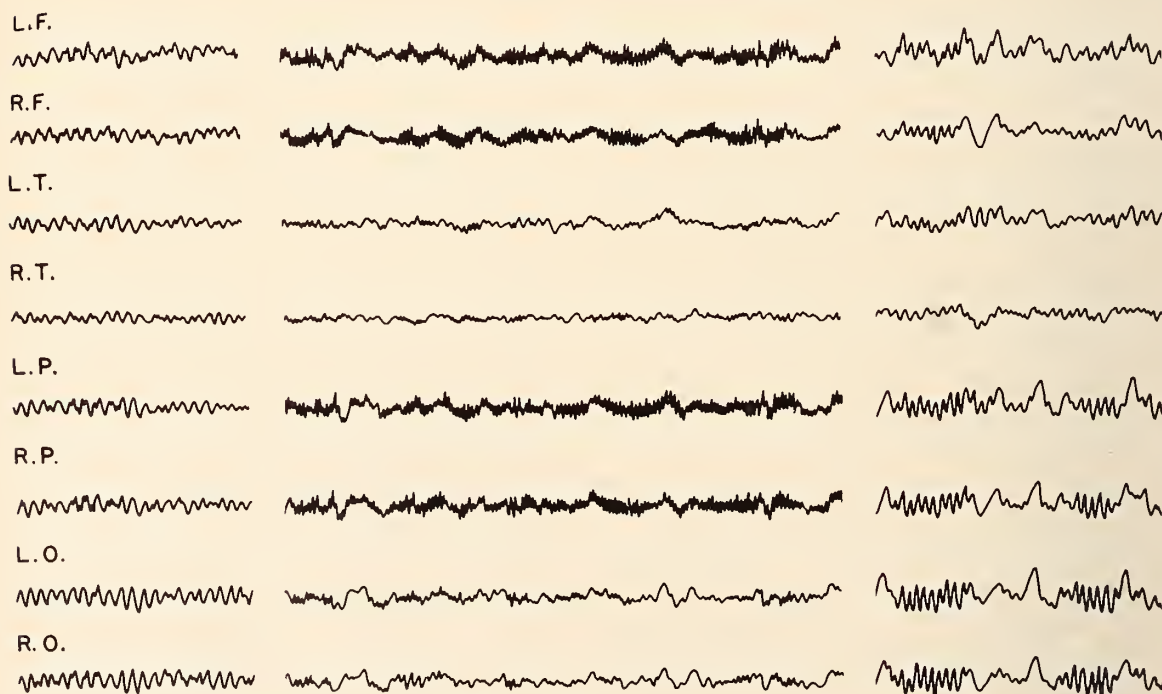


FIGURE 3. Exceedingly fast activity (30-35 per second). The exceedingly fast activity in this case (and in most cases) shows only in drowsiness; it disappears in the spindle phase of sleep.

(F-2), and *exceedingly abnormal fast* (F-3) according to the frequency, voltage, and the amount of fast activity present. Very abnormal fast activity is commonly mixed with seizure activity; it can be produced by a variety of drugs, and it has some relationship to *extreme spindles*.

Exceedingly fast activity (F-3) (Fig. 3) is characterized by an unusual amount of activity in the frequency range above 30 cycles per second, appearing in short bursts and rarely in longer runs. The amplitude is not especially high (5-50 microvolts.) Although most common in drowsiness and light sleep, either natural or induced, exceedingly fast activity differs from other types of fast activity in that it is not produced in normal persons by any known drug. It is almost exclusively an adult pattern. When first described¹⁵ it was rather common, but of late it has become rare; which makes it seem possible that it was produced by some type of encephalitis which has since disappeared.

Exceedingly fast activity, when it occurs as the only abnormality, does not create a strong presumption of epilepsy, though seizures are somewhat more common in persons with this finding than among persons of the same age (from the same clinical source) with normal electroencephalograms. Psychiatric symptoms in our original series commonly lead to a diagnosis of "simple schizophrenia" or "dull psychopath." However, in our present material the incidence of psychosis does not significantly exceed its incidence among a matched group with normal electroencephalograms (unless epilepsy or epileptiform symptoms are present). Among institutionalized psychotics, exceedingly fast activity is rare. Neurosis, some degree of behavior disorder, and a wide variety of neurological signs are the outstanding characteristics of persons with exceedingly fast activity. Patients with this finding are often called "brain tumor suspects" but a tumor is almost never found. The cause of this abnormality is usually unknown; a history of trauma is no more common than among a matching group of patients with normal electroencephalograms.

Focal Fast Activity

A focus of fast activity suggests a localized irritative reaction to injury. It correlates with a history of epilepsy and is commonly associated with localizing neurological signs or symptoms.

Generalized Slightly Slow Activity (S-1)

Slightly slow waking activity, consisting of scattered slow waves with a frequency of 5 to 7 cycles per second in adults (adjusted downward in children), with an admixture of a small amount of slower activity, corresponds fairly closely to what other authors have called "a slight excess of theta activity." It suggests a mild depressive reaction to some type of injury, but the etiology is not indicated. Usually reversible and creating no presumption of structural damage, it is a minimal form of electroencephalographic abnormality. Slightly slow waking activity occurs in 8 percent of adult control subjects. It is often asymptomatic and it is not diagnostic of epilepsy, but seizures are more common among persons with slightly slow activity than among persons with normal electroencephalograms. Such slowing in the presence of a history suggestive of seizures lends some support to a diagnosis of epilepsy.

Generalized Very Slow Activity (S-2)

More-or-less continuous slow activity in the waking electroencephalogram with a frequency of 5 to 7 cycles per second in adults with scattered 3 to 4 per second activity (slower in young children) is evidence of a severe depressive reaction to some type of injury. Such disorder, though not necessarily associated with signs and symptoms of structural damage, is a clearly abnormal finding. It is more highly associated with symptoms of brain dysfunction than slightly slow activity and it is commonly complicated by other electroencephalographic abnormalities.

Generalized Exceedingly Slow (S-3)

Diffuse, very slow (1/2 to 3 cycles per second) waking activity is common in persons with encephalitis. It is often associated with stupor and confusion. It is not an epileptic pattern, but it is suggestive of serious brain disorder. It can be produced

L.F.

R.F.

L.T.

R.T.

L.P.

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R.O.

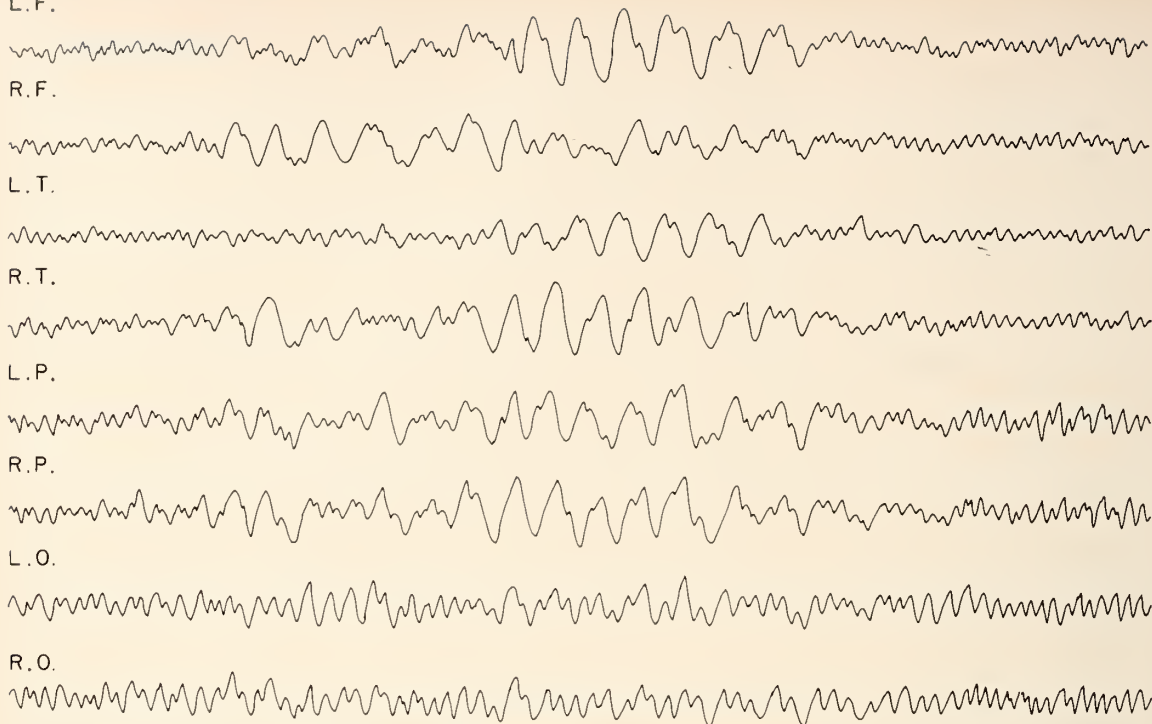


FIGURE 4. Anterior cerebral bradyrhythmia.

in children by hyperventilation, and it appears during post-seizure stupor. It can be produced also by trauma and cerebral edema but not by high intracranial pressure (unless it rises to a level which approaches the arterial pressure). In many children with supposedly uncomplicated measles or other exanthemata, slow activity occurs during the acute and immediate postacute phase, unassociated with stupor or behavioral disturbances. Such slowing commonly clears up without complications. However, it may not clear up and it may transform gradually into spike discharges or other persistent electroencephalographic abnormalities.

Anterior Bradyrhythmia

Paroxysmal very slow waves with a frequency of 2 to 5 cycles per second in the frontal and parietal areas and independent slow waves of the same type and frequency in the temporal areas, occurring somewhat paroxysmally and increasing in drowsiness but disappearing in sleep, constitute a particular type of abnormality called "anterior cerebral bradyrhythmia" (Fig. 4). This abnormality occurs almost exclusively in

adults. It is almost never associated with spike seizure activity or other epileptic or epileptiform patterns, but in a high percentage of cases (48 percent) it is associated with a history of seizures. Very usually signs or symptoms are present which suggest a structural lesion. The most common known etiology is cerebral vascular disease, but in rare cases it is caused by a tumor. Like all types of electroencephalographic abnormality, it can clear up and may disappear entirely over a period of weeks, months, or years. In some cases it clears up and then reappears again. The high incidence of neurological findings often leads to a diagnosis of "question of brain tumor" or "pseudotumor."

Minimal Focal Slow Activity

A minimal focus of slow activity is characterized by infrequent waves of low to moderate voltage with frequencies ranging from 3 to 6 cycles per second. This type of focal slowing is most usually found in the mid-temporal and anterior temporal areas and occurs either unilaterally or bilaterally but independently in the left and right temporal areas. It is almost exclu-

sively an adult abnormality; it appears to be the adult equivalent of the focal moderately slow activity of children. When occurring as the only abnormality, the pattern is only slightly epileptic. It is most usually associated with symptoms of mild brain damage such as dizziness, headache, mild neurological deficits, and impairment of intellectual functions.

This finding is nonspecific as regards etiology; it can be caused by localized interference with circulation or by trauma, it can also be caused by a tumor impinging on the cortex but not invading it, by a slow growing cortical neoplasm, or by a subdural hematoma. It is more indicative of a structural lesion, if it is unilateral rather than bilateral.

Focal Moderately Slow Activity (S-2 Focus)

Focal moderately slow activity indicates a significant degree of depressed function in a localized cortical area. Such focal slowing is nonspecific as regards etiology; it can be caused by encephalitis, trauma, vascular damage, a neoplasm, and by other processes that injure cerebral neurons. Encephalitis is the most common cause. This is characteristically an abnormality of childhood. In young children the focus is likely to be occipital; in older children it is usually temporal. It is associated with a high incidence of seizures, double that found in a matching clinical group with normal electroencephalograms. It is not necessarily associated with a structural lesion but more likely so than when the focal slowing is minimal. Though not usually associated with coma, it is commonly associated with clouded consciousness and neurological deficits.

Focal Very Slow Activity (S-3 or Delta Focus)

Focal very slow activity is a common abnormality. It is more common among adults than among children. Below 10 years of age very slow activity tends to be focal in the occipital areas, and among adults in the temporal and frontal areas. Among both children and adults it is associated with a high incidence of epilepsy. The finding of a slow wave focus in a case of pre-

sumably simple febrile convulsions throws the diagnosis into question and creates a presumption of some degree of brain injury.

A focus of exceedingly slow activity indicates disorganization of neuronal function so severe that it is commonly associated with structural damage. Neurological signs indicating cerebral disorder are usual among children and adults with focal slowing. This finding (in a child without epilepsy) creates no presumption of an intellectual defect. Serial electroencephalograms taken at weekly or monthly intervals show whether the disturbance is increasing or decreasing and may hint at the etiology.

Occipital Slow Wave Focus

A focus of slow activity in the occipital area is the characteristic slow wave focus of infants; it suggests a localized depressive reaction to injury. The degree of slowing (S-1, S-2, S-3) is in general accord with the degree of injury. Such disorder is more likely to be associated with structural damage and less likely to be associated with seizures than a spike focus. However, seizure activity can flare up on occasion from a background of slow activity and focal slow waves, even in the absence of spike discharges, create some presumption that seizures will occur. When they do, they have the same clinical characteristics as seizures associated with a spike focus in the occipital areas. With increasing age occipital slow wave foci tend to disappear or to shift to the mid-temporal area.

Mid-temporal Slow Wave Focus

A mid-temporal slow wave focus indicates some degree of depressive reaction to injury but it is not necessarily associated with structural damage. The likelihood that structural damage is present is greatest when the slow activity consists of irregular extremely slow waves (S-3) with a frequency of 1/2 to 3 cycles per second. Speech disturbances and motor defects are more commonly associated with slow wave foci in the temporal area than with focal spikes in that region. Symptoms of an epileptic type do not occur as commonly in persons with a mid-temporal focus of slow activity

as they do when a spike focus is present, but seizures can flare up on occasion from a background of mid-temporal slowing. When they do, they have the same characteristics as seizures that occur in association with focal spikes in the mid-temporal area.

Parietal (Central) Slow Wave Focus

If the gross anatomy of the hemisphere is normal, focal slow activity recorded from the parietal electrode arises from the mid-central cortex; it is commonly associated with motor weakness or paralysis and is also commonly associated with convulsive seizures and more particularly with focal and Jacksonian seizures. When spikes are absent, seizures are less likely to occur than when the slowing is combined with spiking.

Anterior Temporal Slow Wave Focus

Slow wave activity which is maximal in the anterior temporal region, is the most common slow wave focus of adults. It is a nonspecific depressive reaction to injury and may be associated with a gross pathological process or structural damage to the temporal lobe, but in the majority of cases, focal slowing in this region is an accompaniment of seizure activity and can be regarded as a kind of localized post-seizure stupor rather than a sign of structural damage. If the slow wave focus is uncomplicated

by spikes, the chances of a structural lesion are increased.

With or without spikes a slow wave focus in the anterior temporal region is commonly associated with nonictal psychiatric disorders. In some cases the psychiatric symptoms are severe enough to lead to a diagnosis of "psychosis." Memory defects are more commonly encountered in persons with anterior temporal slow activity than with any other type of focal abnormality. As might be expected, when the focus is bilateral, the symptomatology is usually more severe than when unilateral.

Frontal Slow Wave Focus

A focus of slow activity in the frontal areas suggests localized damage in that region with a resulting depressive reaction. Such disorder is not necessarily indicative of a structural injury. However, it may be structural and it is particularly likely to be so when the activity is extremely slow, consisting of irregular slow waves with a frequency of 1/2 to 3 cycles per second (S-3 or delta focus). The presence of slow activity in the frontal region, when unassociated with spikes does not create a strong presumption that seizures are present or impending. However, it does suggest a slight epileptic tendency, for seizures occur in persons with frontal slow activity more commonly than in the general population.

All references will appear immediately following the final installment.

Snake Venenation in Illinois

Henry M. Parrish, M.D., Dr.P.H.
Columbia, Missouri

Snake venenation (venom poisoning) is not a common medical problem in Illinois. However, when a snakebite emergency arises, it is helpful for a physician to know something about snakes and snakebites in his State, to be able to diagnose snake venenation and its severity, and to become familiar with current concepts of snakebite treatment. The purpose of this study is to provide the practicing physician with the aforementioned information about snakebites in Illinois. Very little has been published previously about the snakebite problem in Illinois. It is known, however, that two people died from snakebite accidents in

From the Department of Community Health and Medical Practice, School of Medicine, University of Missouri, Columbia, Missouri.

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Illinois during the ten year period, 1950 through 1959.¹

Poisonous Snakes

According to Conant,² the following species and sub-species of poisonous snakes are indigenous to Illinois: the timber rattlesnake (*Crotalus horridus horridus*), the canebrake rattlesnake (*Crotalus horridus atricaudatus*), the eastern massasauga or "swamp rattler" (*Sistrurus catenatus catenatus*), the northern copperhead (*Agkistrodon contortrix mokeson*), the southern copperhead (*Agkistrodon contortrix contortrix*), and the western cottonmouth moccasin (*Agkistrodon piscivorus leucostoma*). Coral snakes are not native to Illinois. Thus, there are six species or sub-species of snakes indigenous to Illinois.

All of the poisonous snakes of Illinois are pit vipers. They are so named because of a characteristic pit which is located between the eye and nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well-developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tails. Harmless snakes do not have facial pits, they have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Oftentime people will chop off the head of

CHARACTERISTICS OF SNAKES

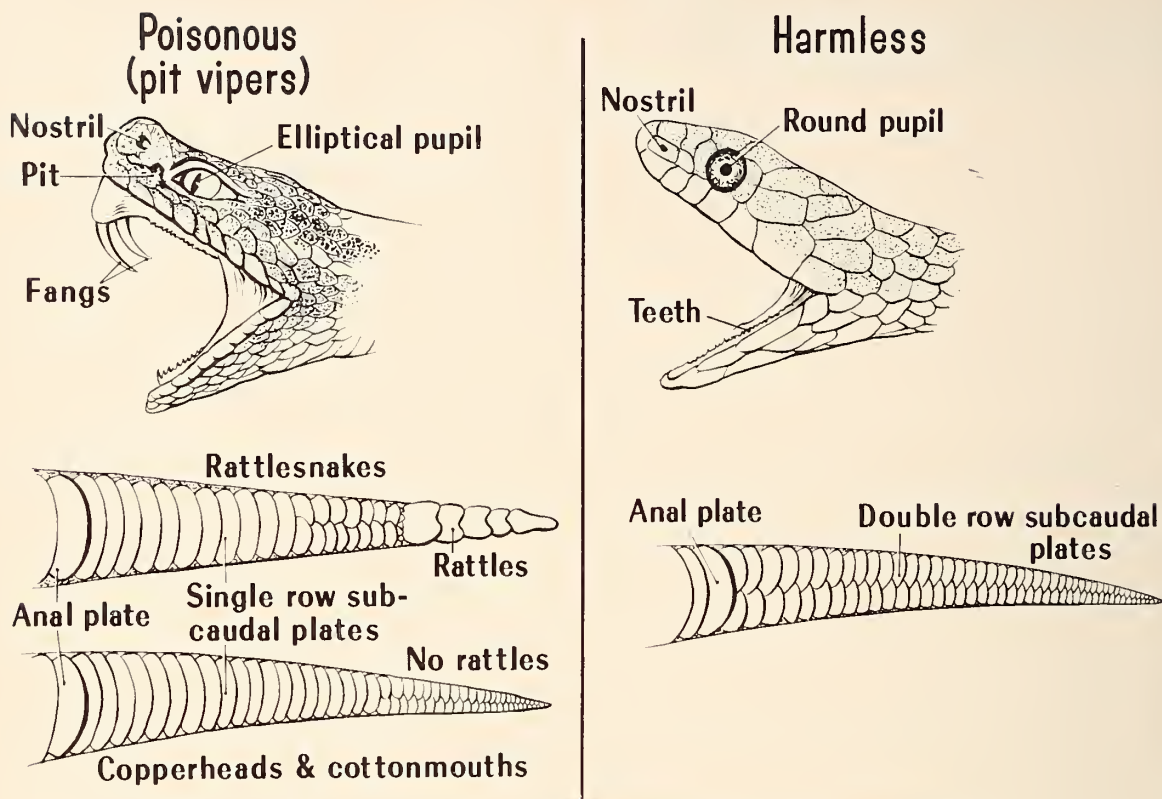


FIGURE 1. Characteristic features of poisonous (Pit Vipers) and harmless snakes.

a snake which has bitten someone and bring the snake's body in for identification. Pit vipers can be identified by turning the snake's belly upward and noting a single row of subcaudal plates just below the anal plate. Harmless snakes have a double row of subcaudal plates. Figure 1 depicts the characteristic features of pit vipers and harmless snakes.

Methods of Study

A questionnaire and letter explaining the purpose of this study were mailed to a "selected" group of Illinois hospitals listed in Hospitals (Journal of the American Hospital Association) Guide Issue. The hospitals selected for this study were general hospitals, children's hospitals and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force and Veterans Administration hospitals also were sent questionnaires. Maternity, tuberculosis

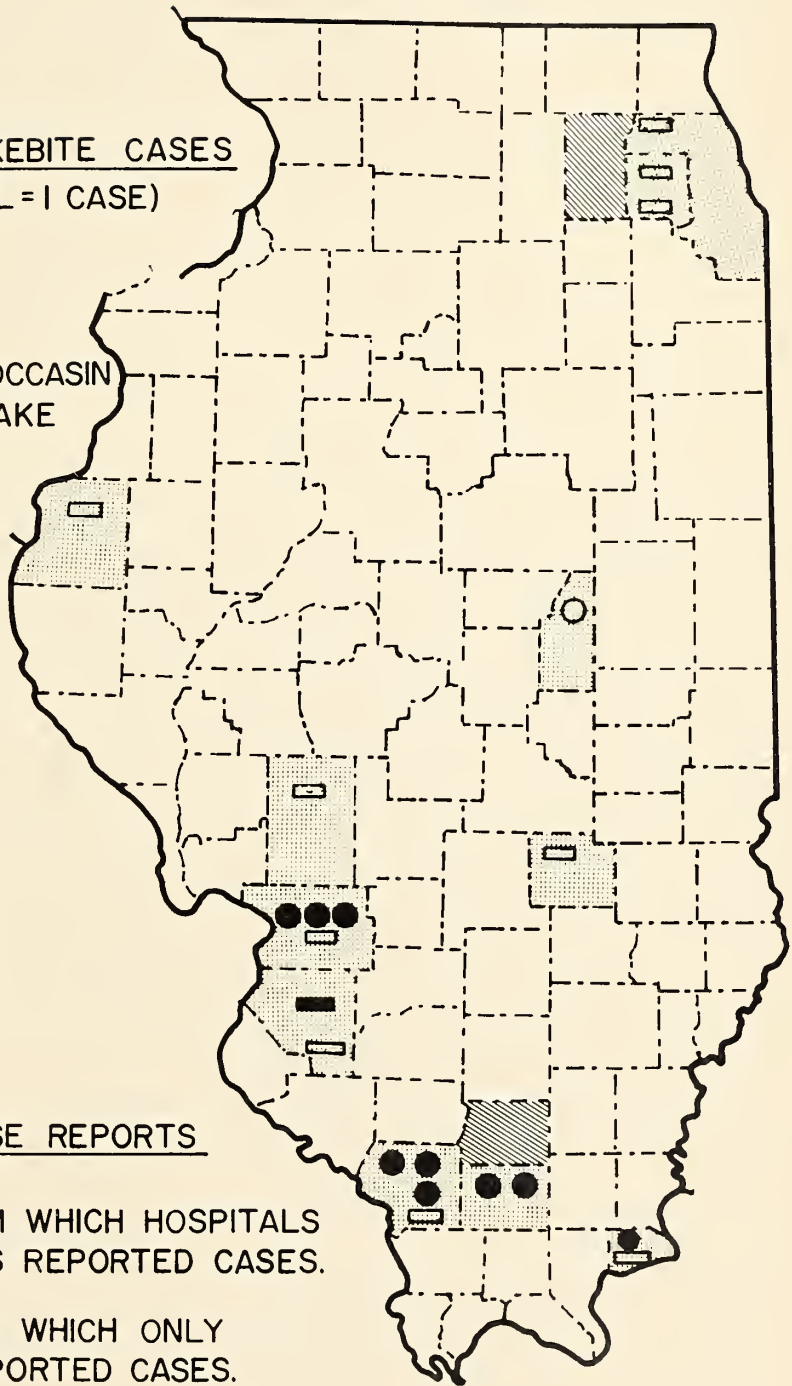
and mental hospitals were omitted as they would not be expected to treat snakebite victims. A total of 247 Illinois hospitals comprise the study group. Each hospital was requested to report all in-patients admitted to the hospital for snakebite treatment during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and out-patient clinic visits. Since some snakebite victims are not admitted to the hospital as in-patients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an out-patient (office, home, emergency room, etc.) and on an in-patient basis. Previous surveys,^{3, 4} have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians, and orthopedic surgeons. Therefore, a random sample of one-third of all the Illinois physicians in these categories

ILLINOIS

HOSPITALIZED SNAKEBITE CASES (EACH SYMBOL = 1 CASE)

- RATTLESNAKE
- COPPERHEAD
- COTTONMOUTH MOCCASIN
- UNIDENTIFIED SNAKE



SNAKEBITE CASE REPORTS

- ▨ COUNTIES FROM WHICH HOSPITALS AND PHYSICIANS REPORTED CASES.
- ▤ COUNTIES FROM WHICH ONLY PHYSICIANS REPORTED CASES.

FIGURE 2. Geographical distribution of poisonous snakebites in Illinois, 1958 and 1959.

of practice who were listed in the A.M.A. American Medical Directory were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the Illinois Department of Public Health.

Results

This report is based on questionnaires returned by 247 (100 per cent) of 247 Illinois hospitals. It is supplemented by questionnaires returned by 1,486 (77 per cent) of 1,926 practicing physicians in the State. The Illinois Department of Public Health indicated that there were no snakebite deaths during 1958 and 1959.

INCIDENCE—Illinois hospitals reported a total of 22 in-patients treated for poisonous snakebites during 1958 and 1959. There were 10 cases in 1958 and 12 cases in 1959—an average of 11 cases per year. Of the 22 snakebites reported during 1958 and 1959, detailed case reports were received for 21 patients and only numbers of bites were reported for one case. *All of the analyses in this paper, excluding the estimate of incidence, were based on the 21 detailed case reports received from hospitals.*

Physicians' reports, when adjusted to account for all Illinois physicians in the practice categories mentioned, indicated that approximately 11 in-patients and 24 out-patients were treated for snakebite accidents each year. The estimate of 11 in-patients treated by physicians and the average of 11 in-patients reported by hospitals were identical. Taking all of these various reports into consideration, I estimate that approximately 35 (11 in-patients and 24 out-patients) people are treated annually for poisonous snakebites in Illinois. This provides an incidence of 0.35 bites per 100,000 population per year.

GEOPATHOLOGY—The geographical distribution of snakebites reported in Illinois during 1958 and 1959 may be seen in Figure 2. The lightly shaded counties are those from which hospitals reported in-patients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded

counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of 21 people hospitalized for snakebite treatment for whom detailed records were available, 9 (43 per cent) were bitten by copperheads, 1 (5 per cent) by a rattlesnake, 1 (5 per cent) by a cottonmouth moccasin, and 10 (47 per cent) by unidentified poisonous snakes. The three northernmost bites by unidentified poisonous snakes probably were inflicted by massasaugas. Most bites by unidentified snakes in the southern one-third of Illinois probably were copperhead bites. Figure 2 shows that copperhead and cottonmouth moccasin bites were confined to the southern one-third of the State. These geographical patterns of bites by various species of snakes are consistent with the ecological ranges of poisonous snakes in Illinois described by Conant.²

TEMPORAL RELATIONSHIPS—The monthly distribution of snakebite accidents has been tabulated. Snakebites were infrequent during the colder months of the year—October through February. In general, snakes are usually inactive and/or hibernating during the colder months. All of the snakebites in Illinois happened from March through September. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and with the time that people have greater exposure due to out-of-doors occupations and recreation. Similar "seasonal epidemics" of venomous snakebites have been observed in New England and North Carolina.^{3, 4}

The time of day when most snakebite accidents happened was the six hour period from 3:00-8:59 P.M. when 10 (48 per cent) people were bitten. The number of bites by three hour periods of time were: 6:00-8:59 A.M., 3 bites; 9:00-11:59 A.M., 2 bites; 12:00 noon-2:59 P.M., 3 bites; 3:00-5:59 P.M., 5 bites; 6:00-8:59 P.M., 5 bites; and 9:00-11:59 P.M., 2 bites. There were no bites reported from 12:00 midnight-5:59 A.M. The time of the bite accident was not stated for one patient.

BITE VICTIMS—There were nine white males, 10 white females, two non-white

TABLE 1.

AGE DISTRIBUTION OF HOSPITALIZED SNAKEBITE VICTIMS IN ILLINOIS, 1958 AND 1959

Age Group (years)	Population at Risk*	No. Bites	Rate per 100,000**
0- 9	2,133,048	3	0.14
10-19	1,554,933	5	0.32
20-29	1,190,640	2	0.17
30-39	1,338,666	6	0.43
40-49	1,319,903	2	0.15
50-59	1,085,776	3	0.28
60-69	806,714	0	0.00
70 or more	601,478	0	0.00

*Based on the 1960 Census of the Population of Illinois.

**These rates are only on hospitalized patients for whom information was available.

males and no non-white females admitted to Illinois hospitals for snakebite treatment during 1958 and 1959. The non-white males were Negroes. Using the 1960 census for the population of Illinois the bites rates per 100,000 population were: 0.20 for white males, 0.39 for non-white males, 0.22 for white females and 0.0 for non-white females.

The age distribution of Illinois bite victims is shown in Table 1. The largest number of bites happened to people 30-39 years of age (6 bites) and those 10-19 years of age (5 bites). Age specific bite rates are much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rate per 100,000 population was: 30-39 years of age (0.43). The lowest bite rates were found among people 60 or more years of age.

An analysis of the occupations of the patients showed that eight were children, five were housewives, three were service workers, two were laborers other than farm laborers, two were clerical workers, and one was a craftsman. It is surprising that none of the victims were farmers or farm laborers.

ACTIVITY AND PLACE—Nine bites occurred while people were engaged in recreation other than hunting and fishing, three while children were playing in their

TABLE 2.

ANATOMICAL SITES OF BITES BY POISONOUS SNAKES IN ILLINOIS, 1958 AND 1959

Anatomical Site of Bite	Side of Body		Total No. of Bites
	Right	Left	
Head, face & neck	0	0	0
Trunk, front	0	0	0
Trunk, back	0	0	0
Upper arm	0	0	0
Forearm	1	0	1
Hand	1	2	3
Fingers	1	1	2
Upper leg	0	0	0
Lower leg and ankle	3	5	8
Foot	2	3	5
Toes	1	0	1
Not stated	----	----	1

own yards, two while fishing, one while hunting, one while handling a poisonous snake, one while working in a hen house and one while reaching into an obscure place. The activity was not stated for the remaining patients.

The place where the bite accident happened is closely related to the activity when bitten. The largest number of snakebites, six, happened near a lake, river or other body of water. Five people were bitten in the woods, three in their yards at home, one inside a hen house, and one on a golf course. The place where the bite took place was not coded for the remaining patients.

SITE AND SEVERITY—The anatomical sites on human beings where venomous snakes inflicted their bites are shown in Table 2. Ninety-five per cent of the bites were inflicted on the extremities—28 per cent on the upper extremities and 67 per cent on the lower extremities. The fingers and hands were the parts most often bitten on the upper extremities. The feet and lower legs, including the ankles, were the parts most frequently bitten on the lower extremities. The site of the bite was not recorded for one patient.

A modification of the clinical classification of pit viper venenation by Wood, Hoback and Green⁵ was used to determine the severity of bites. Bites were classified as follows:

- Grade 0—*No venenation.* Fang or tooth marks, minimal pain, less than 1 inch of surrounding edema & erythema. No systemic involvement.
- Grade I—*Minimal venenation.* Fang or tooth marks, severe pain, 1-5 inches of surrounding edema & erythema in first 12 hours after bite. No systemic involvement usually present.
- Grade II—*Moderate venenation.* Fang or tooth marks, severe pain, 6-12 inches of surrounding edema & erythema in first 12 hours after bite, systemic involvement may be present—nausea, vomiting, giddiness, shock or neurotoxic symptoms.
- Grade III—*Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema & erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for 19 hospitalized cases: 8 (42 per cent) were Grade 0; 4 (21 per cent) were Grade I; 6 (32 per cent) were Grade II; and 1 (5 per cent) was Grade III. For two hospitalized cases the severity of venenation was not stated. There were no deaths among the 21 hospitalized cases in this series. Furthermore, there were no deaths during 1958 and 1959 among the estimated 35 snakebite cases that occurred annually. The case-fatality rate for snake venenation in Illinois is estimated to be less than one-half of one per cent. This is confirmed by the fact that there were only two snakebite deaths in Illinois from 1950 through 1959.¹ One death in 1955 involved a 42 year old farm laborer who was bitten by a rattlesnake while cutting timber. He died 30 minutes later. The other fatality occurred in 1957 when a 67 year old zoo curator was bitten by a foreign snake, an African boomslang. He died the following day. Contrary to popular belief, few patients bitten by native snakes die within the first few hours following a snakebite. About 70 per cent of them die from 6-48 hours after venenation takes place.⁶ Large rattlesnakes (*Crotalus sp.*) kill more people than any other poisonous snakes in the United States.⁶

Treatment

The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. The constricting band should be applied only tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation* and it should be released every 10-15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction (I.S.) is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first-aid kits effective for removing pit viper venom. Incisions, one-quarter inch long and one-eighth to one-quarter inch deep, are made into the subcutaneous tissues over the fang punctures. A few (3-5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to I.S., in treating all serious pit viper bites. Antivenin *Crotalidae* Polyvalent (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should

receive a skin test before antivenin is given. For Grade I venenations antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000cc. of normal saline may be given intravenously.⁷ Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.⁸ Injection of antivenin into the local bite area is not a particularly effective way to administer antivenin. We have found the following amounts of antivenin useful in treating the various Grades of venenation: Grade 0 (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10cc. (one ampoule) of antivenin; Grade II (moderate venenation) requires 30-40cc. of antivenin; and Grade III (severe venenation) requires 50cc. or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as

packing an extremity in ice or using ethyl chloride.⁸ In our opinion, cold therapy should not be used in treating pit viper bites.

Summary

An estimated 35 (11 in-patients and 24 out-patients) people in Illinois were bitten by snakes annually—an incidence of 0.35 bites per 100,000 people. However, the estimated case-fatality rate was less than one-half of one per cent.

Of 21 in-patients reported in detail by Illinois hospitals during 1958 and 1959, nine (43 per cent) were bitten by copperheads, one (5 per cent) by a rattlesnake, one (5 per cent) by a cottonmouth moccasin, and 10 (47 per cent) by unidentified poisonous snakes. "Seasonal epidemics" of snakebites occurred with all of the bites inflicted from March through September. Ninety-five per cent of the bites were on the extremities—28 per cent on the upper extremities and 67 per cent on the lower extremities. Current snakebite treatment is discussed.

Acknowledgment

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EVALUATION OF A NEW ORAL LAXATIVE FOR ROUTINE POSTPARTUM USE

*Lawrence I. Bernard, M.D.,
F.A.C.S., F.I.C.S.,
Carl Jarolim, M.D., and
Lolita Tumaneng, M.D./chicago*

TABLE 1.

EVALUATION OF THERAPY AND PATIENT ACCEPTANCE

Comments	Patient Acceptance	Correction of Constipation	% of Series
Excellent	22	22	25
Good	64	64	73
Fair	2	2	2
Poor	---	---	---

RE-ESTABLISHMENT of normal bowel function is particularly important during the management of postpartum patients. Gentle, easy evacuation without intestinal irritation is essential if such patients are to have freedom from bowel discomfort during the puerperium. The historic use of enemas, bulk laxatives and cathartics no longer meets many of the needs of modern obstetrical procedure and patient acceptance of these older laxative methods is seldom enthusiastic.

A safe, non-irritant oral laxative would seem, therefore, to offer several advantages for routine use during the postpartum period. Such an agent, combining a mild peristaltic stimulant with a new fecal softener in a single capsule, has been developed for routine postpartum use. In order to evaluate its clinical efficacy, this preparation (Doxidan)* was administered to a series of postpartum patients receiving routine hospital care following delivery. Previous clinical investigators have demonstrated that

the use of this combination provides safe, gentle laxation with minimal side effects while significantly reducing the need for enemas and nursing care.¹⁻⁷

Material and Method

A clinical trial of a new laxative agent (Doxidan) was conducted in 88 hospitalized patients, all of whom were delivered vaginally, with therapy being initiated on the first postpartum day. Most patients received 2 capsules at bedtime and a dosage schedule of 1 to 2 capsules was maintained during their period of hospitalization. For the purpose of this study, the number and frequency of bowel movements, consistency of stools, side effects and general comments on the effectiveness of the laxative were recorded. The use of other anti-constipant medications, enemas (both prior to and following delivery) and medical findings were noted. The patient's reaction to this new agent was elicited before her discharge, particularly in regard to her acceptance of it and the prevention or correction of constipation (Table 1).

Results

Of the 88 patients who received Doxidan,

*Doxidan (calcium bis-diethyl sulfosuccinate with danthron). Supplied by Lloyd Brothers, Inc., Cincinnati, Ohio.

80 had spontaneous bowel movement following administration of the initial dose and 7 patients had a movement after the second dose. An enema was requested by one patient on the third postpartum day. In most cases, the stools were soft, well-formed and easily evacuated. A total of 73 patients, or 83%, received codeine for perineal pain during therapy with Doxidan.

The most common side effect encountered was mild gas pain and at no time was the medication discontinued because of it nor were analgesics requested. No allergic reactions were evident and there was no incidence of diarrhea (Table 2).

The addition of danthron (1, 8-dihydroxyanthraquinone), a mild peristaltic stimulant, to a superior fecal softener (calcium bis- [dioctyl sulfosuccinate]) eliminates such problems as painful defecation, bowel irritation and fecal impaction which may be encountered following the use of bulk laxatives and saline cathartics. The excretion of irritant purgatives into the milk of nursing mothers is also avoided.

The usefulness of calcium bis- (dioctyl sulfosuccinate) in the management of constipation has been clinically demonstrated.³ By penetrating the fecal mass and reducing its interfacial tension at the aqueous-lipoid phase, this compound effectively softens the stool so that it can be easily eliminated. It does not cause intestinal irritation nor interfere with normal bowel function even when used for prolonged periods of time. Thus, the combination provides safe, gentle laxation with mild peristalsis of intestinal content which has been optimally softened.

Summary and Conclusions

The clinical effectiveness of Doxidan for routine use in postpartum patients has been evaluated in 88 cases. Patient acceptance and correction of constipation was good to

TABLE 2.

INCIDENCE OF SIDE EFFECTS		
Side Effects	Number of Patients	% of Series
Gas	28	32
Fullness	2	2
Cramps	9	10
None	49	56
Total	88	100

excellent in 98% of the patients treated. Mild, transitory gas pains were noted in 32% of these patients but did not necessitate discontinuance of therapy nor analgesic medication.

In comparison to other agents for the management of constipation, Doxidan has proved its wide acceptance for clinical use, since it is safe, effective and easy to administer. Thus, the advantages of this form of laxative therapy are improved patient management, acceptance, freedom from side effects and reduction of the need for enemas, unpleasant cathartics and lubricants. In the recommended dose of 1 or 2 capsules daily, Doxidan provides near ideal laxative therapy for the postpartum patient.

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EXERCISE IN OBESITY: PRACTICAL CONSIDERATIONS

*Frank L. Bigsby, M.D. and Cayetano Muniz,
M.D./chicago*

A FULL-FLEDGED understanding of obesity is dependent on a knowledge of various types of patients seen clinically.¹ The discussion of such topics as prognosis, incidence, altered physiology, motivation, psychotherapy, or exercise are meaningless without a definite obese classification. A discussion of the role of exercise in obesity will serve to illustrate this view.

The role of exercise in the practical management of obese patients is highly controversial. The advocates of exercise argue that vigorous physical exertion causes a definite increase in metabolic rate and caloric output. A cyclist, for example, riding the equivalent of one hundred miles in four hours utilizes energy at the rate of forty-five hundred calories an hour, theoretically resulting in the loss of about one pound of fat each hour.

Many arguments belittling the role of exercise have been advanced. It is a fact that exercise itself may do little to bring about a loss of fatty tissue: indeed, by stimulating the appetite, exercise may at times bring about a weight increase.

Which side of the controversy is the busy physician to take in managing his obese patients? Is it easier to induce a patient to routinely refrain from eating a 270-calorie piece of custard pie, for example, than to routinely walk the extra three miles needed to burn 270 calories? The decision

may be to join one or the other camp and thereafter be unrelenting in voicing an opinion; or, it may be to avoid the topic completely, allowing the patient to decide, and thereby aggravate an already confused state of mind existing in many obese individuals.

The authors believe the answer to the question of exercise rests with the individual patient: his degree of motivation, status of rapport and insight, environmental-occupational factors, past participation in sports, educational background, and a host of other factors. A practical method for attaining a more comprehensive understanding of the role of exercise is to categorize patients to a degree that will facilitate the choice of exercise to be suggested, or indeed whether exercise is to be recommended at all.

Natural Make-up Obesity

A patient inclined to natural make-up obesity usually weighs between one-hundred sixty and two hundred pounds, has a heavy body structure, broad features, large hands and feet, and a heavy muscular development. Women of Eastern European descent provide sound examples of this general type. Their actual excess adipose deposits may be minimal so that the amount of overweight is only fifteen pounds in many instances. Here are included apparently

healthy, euphoric, robust obese individuals who display a tendency to hypertension, diabetes, gout, lithiasis and cardio-vascular accidents. As a rule, the state of emotional and physiological tension is not too pronounced. Frustration about size may be evident, and it is not surprising that they sometimes mistakenly link large size with obesity. The loose acceptance of so-called "normal weight" found on a standard weight-chart, regardless of applicability, plays a prominent role in promoting frustration.

Establishing an objective program of exercise in most of these patients is no problem. Actually, the patient is quick to approach the subject in many instances. Care must be exercised to limit physical exertion to a level compatible with dietary requirements and physical condition: the cardio-vascular system must be guarded, the appetite must not be stimulated. An interesting observation relating to this patient is that leading an active physical existence seems to be a personality trait. As youngsters, they participated in sports, were aggressively successful, liked to win, and often were characterized as being surprisingly agile for their size. One automatically thinks of the modern, quick, aggressive interior lineman in professional football, when discussing natural make-up obese males. He weighs two hundred and sixty pounds and runs like a halfback.

Exercise may not be beneficial in all cases of natural make-up obesity. These patients often report that strenuous physical exertion does not cause weight loss. This is undoubtedly due to the fact that their size is related to muscular development rather than fatty deposits. A dilemma exists: the patient likes to exercise—yet must be controlled because of possible cardio-vascular accidents in advanced years, and the likelihood that exercise will cause little weight loss. Natural make-up obese patients are likely to continue a prescribed exercise program indefinitely. Few are prone to revert to sedentary habits.

Occupational-Environmental Obesity

In this classification are included business

executives, white collar workers, socially inclined housewives and women busily engaged in contributing financial aid to worthy causes. A business executive is often well educated, inclined to be outgoing in nature, and interested in some form of competitive sports as the result of earlier youthful participation. A business lunch with clients or cronies may be attended by a round of drinks, while a cocktail is frequently followed by a heavy meal and a series of highballs.

The counterpart of the business executive is the housewife who is socially inclined, with the bridge luncheon and accompanying cocktails, the cocktail hour, and an after-dinner drink or two are frequent occurrences. Such people are commonly in their mid-thirties before finding themselves inclined to bulge about the middle without being conscious of an appreciable change in their caloric intake habits. Unfortunately, they are motivated by a desire to maintain a desirable figure without, in any way, surrendering their mode of social existence. Many business executives and socially minded women delude themselves with the thought that the lives they lead are essential for business and social success.

Fortunately, the motivation to maintain a trim figure is commonly high in this patient. This feature is most important when the physician recommends exercise. Additionally, as previously stated, many individuals in this classification are well educated and aware of the satisfaction and social benefits to be derived from tennis, golf, bowling, skiing, swimming, etc.

Included in this class is the middle-aged executive tending to corpulence who says he will have to start playing golf again. Age, itself, should be no deterrent to exercise. Of course, it is inadvisable, even hazardous, for anyone of any age—after a long lapse into inactivity—to take a sudden plunge into strenuous or taxing exercise. Such a person should be carefully checked to see if he has any organic trouble that exercise might aggravate; there is real danger in imposing an increased burden upon cardio-vascular, renal, and respiratory systems operating under a load of increased

metabolism perhaps even already anatomically or physiologically damaged.

The physician should recall that physical efforts of most adults are usually fixed in rather narrow limits by their occupational commitments. Any major modification of this is usually impractical. The best approach to exercise here is to go into action gradually—a little today, a little bit more tomorrow—after that, keep at it *without backsliding*.

Natural make-up obese and occupational-environmental obese patients represent two clinical types in which the physician will encounter little serious opposition when a realistic exercise program is suggested.

Familial Obesity

To illustrate familial obesity let us consider a female patient, middle-aged, married, with several children. She is often constitutionally small, perhaps five feet, two inches tall, with fine features and an excellent complexion, having small hands and feet, and possessing an essentially happy, stable, uncomplicated personality. She is usually not a hypochondriac by nature. Her weight is likely to be excessive, as much as sixty to seventy pounds overweight, with a generalized fatty distribution in the breasts, upper arms, abdomen, hips and thighs. Her weight at the time she attended high school, or when she married, was probably ninety-five to one hundred and twenty pounds. Following her first pregnancy, weight increase became a problem—a problem which became greater with each subsequent confinement. In essence she is a true “homemaker,” delights in cooking for her family, joins their dietary excesses, does her own baking and housework, does not relish dressing up and dining out, and is not a women’s club devotee. She may welcome visitors several times a day with something to eat and drink. There may be a strong liking for starchy foods, rich and highly seasoned foods, and bakery goods. The eating pattern is inherited; obesity is not.

Under these circumstances how strong is the motivation to lose weight? The patient feels well, is content with her lot in life, is not concerned with dress size, and is seldom

on public display. Her husband is equally unconcerned with her weight, for his home, family, and food requirements are expertly handled by his wife. Motivation to lose weight is notoriously poor; this fact alone is ample to defeat the possibility of a sustained exercise regimen. Prior to her marriage the patient may have enjoyed dancing and an otherwise active social life; most likely was gainfully employed; with the advent of marriage and repeated pregnancies all outside interests and activities vanished.

Related to poor motivation is marked unwillingness to carry out special exercises to aid a reducing plan. The familial obese patient endlessly climbs the steps of her home, she shops, stoops, and bends. The conviction that household chores represent sufficient physical exertion precludes the possibility of a sustained and productive program of exercise. Finally, overweight in these patients is primarily dietary rather than sedentary in character, and a suitable reduction in caloric intake invariably yields results.

Obesity in Adolescents

Puberal obesity and developmental obesity are the two clinical types recognized in the younger generation of patients. These are included in this discussion because they require a different therapeutic approach in respect to exercise.

Puberal obesity, which, as the name signifies, occurs during puberty, is characterized by a pronounced increase in size and weight. When this becomes evident to child, parent and the outside world, the physician is frequently consulted.

In puberal obesity the child is blessed with sufficient emotional stability to enable him or her to weather this teen-age problem. These patients often have parents that are mature and understanding and thus there is a stable and affectionate home environment. The physician is consulted because the patient desires to control his figure and not as a result of parental pressure.

Therapy should deal with mild measures aiming to prevent an additional increase in

weight and not an actual loss. When a normal and gradual fondness for the opposite sex occurs, together with a mounting interest in sports and school activities, the patient will for the first time spark necessary motivation for controlling weight. It is precisely at this juncture that the observant physician can be influential in guiding this cooperative youngster. The role of the physician is to anticipate the advent of improved motivation and not force the issue of diet and exercise. With the advent of motivation an effective plan that includes a fair share of physical activity is readily accepted.

Developmental obesity, also, has its inception in the pre-teen or teen-age youngster. Patients afflicted by developmental obesity may be doomed to spending a lifetime in quest of a satisfactory answer to the tantalizing problem of excess weight.

A classic example of developmental obesity is supplied by a young person who experiences a rather sudden gain in weight and size. Instead of being supported by a calm, stable, unemotional attitude on the part of the family, the patient often finds himself in a climate of opposing reactions. Too many arguments, threats, bribes, tears, and other emotional scenes emphasize the battle of the bulge. The eating pattern is similar to that of most teen-agers. In some instances, however, satisfaction is perceptibly more difficult to obtain; undoubtedly, there is much surreptitious consumption of candy bars, potato chips and the like because of scenes initiated by gastronomic demands. There is likely to be a marked distaste for physical exertion. During the initial interview, the physician will soon sense that the parent has forced the issue of overweight and that emotional upheavals among members of the patient's family are likely to ensue.

The medical management of developmental obese patients represents a true test of the physician's interest and patience. Advice about diet and exercise falls on deaf ears. Noted authors have written at length on the psychiatric aspects of overweight in the young. Clinically, it is unfortunate that irreparable damage may have been done in

TABLE 1

Hourly Caloric Expenditures from Various Activities*			
Activity	Caloric Output**	Activity	Caloric Output**
sitting	15	housepainting	150-200
sitting and writing	20	carpentering	150-200
dressing	30-40	stone-masonry	300-400
walking (2 mph)	200	golfing	300
walking (3 mph)	270	gymnastics	200-500
walking (4 mph)	350	playing tennis	400-500
running	800-1000	skiing	600-700
dancing	200-400	wrestling	900-1000

*All caloric output figures are exclusive of the basal metabolic rate, which should be added to the activity figures in order to determine total energy expenditure.

**Based on the energy expenditure of men weighing 145-170 lbs. Larger people expend more energy—smaller people less.

the instance of developmental obesity by the time the consultant sees the patient.

The role the family physician may play in decreasing the incidence of developmental obesity is vital. Rapport is usually well established with the entire family and the physician may be in a prime position to aid a youngster who has experienced a sudden spurt in size and weight. The physician, in his knowledge of the family, may be aware that one or both parents are immature and unstable; that all is not calm and serene at the dinner table; that any number of circumstances exist which can only result in a high degree of frustration in the patient.

The physician can be instrumental in establishing a realistic dietary and exercise program. This program will be most effective if it precedes the appearance of advanced signs and symptoms of developmental obesity. Care should be taken that all members of the family understand the goals of treatment and that a united front exists. Emphasis should be placed on the fact that weight control is the patient's responsibility alone. Chemotherapy must be resorted to with extreme caution, as early use of anorexigenic agents may prematurely foster the knowledge that there is an outside agency available for weight

control, and that this agency is a substitute for diet and exercise.

Lack of insight is a predominant characteristic in developmental obese youngsters. This may be related to misinterpretation of so-called "normal weight" found on a standard weight chart; the observant physician may recognize this as a source of psychic frustration and quickly divert attention from the misleading figures on the chart. If it is estimated that his patient has the skeletal and muscular systems of a one hundred-and-eighty pound individual, the physician must let such belief be known in no uncertain terms. It is far better to have a patient emerge a mature, happy, moderately obese, large-sized adult than be doomed to spending a lifetime searching for an answer to an unanswerable problem.

Finally, the physician should not belittle, browbeat, threaten or abandon this patient. His every resource should be utilized to keep the exercise regimen from being discontinued. Frequent consultations with the patient, the parents and school officials are in order. The school physical-education instructor should be consulted, and close co-operation suggested, relative to required exercise.

Should an exercise program be decided upon, the following general observations² and table showing hourly caloric expenditure from various activities are useful information. The authors present this information in mimeograph form to patients starting an exercise program.

General Rules for Exercise

For exercise and toning of the body as a

whole, there have been many special exercise systems drawn up. One does not have to set aside valuable time, follow set procedures, or purchase expensive apparatus for this purpose. When the distance is not too great, walk instead of using the automobile or bus—indeed, some authorities assert that three twenty-minute walks daily will give the average person all the exercise he requires. This, of course, does not mean that calisthenics are not beneficial. As to "spot-reducing," there is no evidence whatsoever that regional exercise has any advantage over general exercise; for certain purposes such as improving posture, supporting a sagging abdomen, etc., specific exercises are not without value.

1. Begin and end each exercise period with deep-breathing exercises.

2. Do not exercise when weary; the morning is a good time for special exercises.

3. Take no violent exercise shortly after eating.

4. Make the exercise as general as possible, so that all parts of the body are affected by it.

5. Do your exercise regularly, every day, not sporadically at intervals.

6. Do not despair when the first week does not show any outstanding results — regular, long-time effort is required and one should reconcile himself to the fact cheerfully.

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SPECIAL LEGISLATIVE REPORT

The Supreme Court of the State of Illinois in the case of Estate of Bernice Brooks, Alleged Incompetent vs. Bernice Brooks, et al, Docket No. 38914, held that Mrs. Brooks should not have been compelled to accept a blood transfusion against her will and against her religious beliefs. This case was decided in January of 1965 and no one asking for a rehearing, the case has now become final.

Mrs. Brooks, who is a member of the religious sect known as Jehovah's Witnesses, was suffering from a peptic ulcer and was advised by her physician that death would ensue within twelve to twenty-four hours unless she received a blood transfusion. Mrs. Brooks and her husband refused the blood transfusion and released

the attending physician and hospital from all liability. The physician in charge of the case then contacted the State's Attorney and the above case was brought to the Probate Court of Cook County.

Judge Dunne, Chief Judge of the Probate Court, allowed the petition and the order was then issued directing the guardian to consent to the transfusion. The transfusion was made, Mrs. Brooks recovered and she then sought this action to have the proceedings expunged from the record.

While the Illinois Supreme Court held that the decision of the Probate Court was improper in this case and the transfusion should not have been ordered, there were circumstances present in this case which would probably not arise in other cases and a complete analysis of this decision needs to be made in order to determine the exact holding of the Supreme Court.

In arriving at the decision the Court reviewed and discussed other similar cases, both in Illinois and other jurisdictions. The Court pointed out that compulsory vaccination cases are decided upon the grounds that society can and must protect itself from the danger of loathsome and contagious diseases; polygamous marriage bans have been upheld as injurious to public morals and welfare; prohibition against snake handling in religious ceremonies has been upheld upon the same grounds; and, a blood transfusion to a minor child has been upheld upon the grounds that he was incompetent to make a proper and binding decision. In a case in the Federal Court a blood transfusion was ordered to be given to an adult member of Jehovah's Witnesses sect but in this case, the patient stated that while the transfusion would be against her

COURT RULES AGAINST PHYSICIAN WHO GAVE TRANSFUSION TO JEHOVAH'S WITNESS

will, if the Court ordered such a transfusion, the matter would have been taken from her hands and she would be blameless under her religious beliefs. The Court then decided to "act on the side of life" and ordered the transfusion.

From the above it becomes quite apparent that the religious freedom guaranteed by the Constitutions of Illinois and the United States means that a person may practice his religious beliefs so long as his actions, or lack thereof, are not harmful to society. In this case Mrs. Brooks did not have a contagious disease, was not performing any actions which were injurious to public morals and welfare, was competent to make a decision in her own behalf and had indicated as strongly as possible that she did not desire a blood transfusion, even though the lack thereof could result in her death. The children of Mrs. Brooks were adults and her death would produce little, if any, adverse effect upon society. This decision applies only to this factual situation and might not arise again in the future.

It is the feeling of Illinois State Medical Society that the physician involved in this particular case followed the correct procedure from both a legal and moral point of

view and that this same procedure should be followed by all physicians in any future cases wherein the patient refuses treatment, the lack of which might cause death. The procedure to be followed would be for the physician to immediately contact the State's Attorney of the county suggesting that an action be brought asking for authority to provide the necessary treatment. If the State's Attorney should refuse to bring such an action it would be our suggestion that the doctor in question contact his own attorney so that a proceeding could be brought in the Circuit Court, again seeking an order for compulsory treatment.

The attending physician cannot compel treatment if the patient or the parents or guardian of a minor refuses such treatment no matter how desperate the situation may be, so unless the facts are identical with those in this case, and in every instance of a minor or incompetent, the direction and order of a court of competent jurisdiction should be sought. By following the procedure outlined above the attending physician will have done everything within his power to have saved a life and thus will have discharged his legal and moral obligation to his patient and society.

PHYSICIAN SYNDROME

There is a sub-type of the lazy husband syndrome which I have seen often enough to have given it a name. It is the "physician syndrome." This is a disease that had its onset while the patient's husband was in medical school; it was aggravated by internship; and became chronic when he started private practice. The physician is particularly vulnerable because he was worked hard, is not lazy, and all day long has been "giving" to his patients. So, it is understandable that he should come home expecting to have his virtue rewarded, in some degree, by his wife and family. Yet, all his good acts on behalf of his patients (which, he must admit, give him considerable satisfaction) haven't benefited his wife one bit. She, as much as any other woman, needs some of the care and concern that her husband so lavishly hands out to his patients. *A. S. Norris, M.D.; The Tired Mother, J. Iowa Med So., August, 1964.*

EDITORIALS

HOW MUCH OXYGEN FOR INFANTS WITH THE RESPIRATORY DISTRESS SYNDROME?

IN THE April issue of *Pediatrics* for 1965 Clement Smith and his group emphasize the importance of massive oxygen therapy in the treatment of infants with the respiratory distress syndrome associated with hyaline membrane disease.¹

Doctor Smith is the editor of *Pediatrics* and a world renowned authority on the respiratory physiology of the newborn. He states that in infants with the diagnosis of respiratory distress syndrome associated with hyaline membrane disease there is a large right to left shunt.² His group reports that in the presence of right to left shunts greater than 65%, the blood will not be fully saturated even by breathing 100% oxygen. He concludes that there is little danger of retrolental fibroplasia during oxygen therapy for extensive involvement of the lung in cases of the respiratory distress syndrome.

Warley and Gairdner in 1962 came to the same conclusion about the need for high oxygen concentrations in premature infants with large right to left shunts associated with severe respiratory distress syndromes.³ In these cases much of the blood that flows through the lung makes no contact with the functioning alveolae. They state that oxygen concentrations up to 90% may be needed to restore normal arterial saturation.

It should be noted that the Committee on the Fetus and Newborn of the American Academy of Pediatrics states in the publication entitled *Standards and Recommendations for Hospital Care of Newborn Infants* that "The intelligent use of oxygen may be the means of saving the lives of hypoxic, dyspneic and cyanotic infants. It would be unwise to deny arbitrarily adequate oxygen, and perhaps life, because of possible injury to the eyes of some."

It is also important to stress that oxygen therapy, no matter what the concentration above room air, should be discontinued as soon as the need for it has passed.

It is hoped that pediatricians who have been fearful of retrolental fibroplasia find that this new information provides a scientific basis for increasing the oxygen in incubators beyond 40%, if necessary, to meet the needs of infants with severe respiratory distress.

Harvey Kravitz, M.D.

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GENERAL PATHOLOGY. Sir Howard Florey.

The text consists of a compendium of lectures given to medical "honour" students at Oxford. The presentations are given by scientists who are unusually prominent workers in their respective fields. This edition of an already widely read and renowned textbook of general pathology has been extensively revised, and one new subject has been added, namely the immunology of tissue transplantation.

The revision includes numerous electron micrographs which have been carefully selected and are of superb quality. The chapter on inflammation by the senior author is filled with these illustrations which help to elucidate leucocyte migration and other concepts of the inflammatory process. Many other chapters are similarly improved. One need only look at the list of contributors to obtain an idea of the high standard of this book, Florey, Cameron, Pickering, Robb-Smith, Ritchie and many others.

Some controversial concepts are present in an attempt to give the reader a broad understanding of the subject matter rather than to develop a didactic opinion. This is the reason for which the book is intended as it stimulates independent thinking and doubt.

The volume is not intended to cover general pathology completely. Instead, variegated subject matter is presented in a generally well written, concise and interesting fashion. The text is not organized in the usual manner for a book of this type, and the subject matter varies from the usual general subjects such as inflammation, tumors and healing to such things as the mode of action of antibacterial substances and immunity.

This book is highly recommended for students of pathology who want more discussion about a given subject than the standard American texts present, and for those who wish information about many of the recent significant advances in disease states which have evolved from the use of the experimental method.

M. C. Wheelock

ABT-GARRISON HISTORY OF PEDIATRICS published by W. B. Saunders Company.

This book is a composite. The first and largest portion is a reprint from Abt's System of Pediatrics, Volume I published in 1923 and edited by the great physician and a founding father of pediatrics, Isaac A. Abt, M.D. Fielding H. Garrison wrote the section, History of Pediatrics, for this monumental work.

The second part of Abt-Garrison History of Pediatrics written by Arthur F. Abt, M.D. deals with recent developments and advances in the field of pediatrics. The numerous subjects, out of necessity, are touched upon in a general way. Some references are given if more detailed study is desired.

L. Martin Hardy, M.D.

INDUSTRIAL AND TRAUMATIC OPHTHALMOLOGY.

Symposium of the New Orleans Academy of Ophthalmology. Published November 16, 1964, C. V. Mosby Company, St. Louis, 321 pages, price \$14.50.

This book is the result of a symposium held at the 12th annual session of the New Orleans Academy of Ophthalmology in February of 1963. It is probably the most definitive and practical book I have yet read on the relationship of ophthalmology to industry. Included are discussions of: how to determine if the employee has proper vision to do his job, accident prevention, emergency eye care, the ophthalmology of driving, chemical injuries, traumatic and radiational injuries and the various aspects of disability, the evaluation of which is so often perplexing to the ophthalmologist. There are numerous figures and illustrations which make the book most readable. This book is highly recommended not only to the ophthalmologist but to any physician who has to deal with ocular emergencies.

Thomas Chalkley, M.D.

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Rx Reviews

and New Products

INJECTABLE BETAMETHASONE

Celestone Soluspan, a new and unique injectable form of betamethasone, has been introduced by the Schering Laboratories Division of Schering Corporation.

Celestone Soluspan is the first corticosteroid injectable to provide both immediate and long-acting anti-inflammatory action in a single dose.

This double action effect—both prompt and sustained — is recommended for regional as well as systemic treatment of acute and chronic inflammatory diseases such as rheumatoid arthritis and bronchial asthma, acute self-limited diseases such as poison ivy and other contact dermatitis conditions, and for patients who cannot be treated with oral medications.

Celestone Soluspan, a prescription product available through physicians only, is produced in 5 cc. multiple dose vials which contain only 3 milligrams of particles per cubic centimeter, a particle density which is more than 90 percent less than its major competitors.

This decreased density allows Soluspan to flow freely through small-bore needles and therefore helps eliminate such side effects as post-injection flare and sterile abscesses. It also greatly reduces the incidence of such side effects as dimpling, blanching and skin atrophy.

In addition to offering all the benefits of soluble preparations plus its unique immediate and sustained relief effects, Celestone Soluspan is economical in that it costs less per equivalent dose than other leading corticosteroids.

Betamethasone, a Schering discovery, has been marketed in tablet form since 1961 and a cream and liquid form since early last year.

NEW PAIN KILLER IN MORPHINE RANGE OF POTENCY

A New Drug Application covering pentazocine, a new non-addicting pain killer in the morphine range of potency, has been filed with the U.S. Food and Drug Administration by Winthrop Laboratories, a division of Sterling Drug Inc. Winthrop's brand name for the new compound—the first potent non-addicting analgesic—is Talwin.

In making this announcement today (March 17), Dr. Theodore G. Klumpp, Winthrop president, said that "the search for a non-addicting substitute for morphine has been carried on for generations by scientists throughout the world. Stimulating research activities in recent years has been the increasing problem of drug addiction."

Talwin underwent most extensive clinical trial, Dr. Klumpp said, "in view of the worldwide medical and social significance of a potent pain killer that produces effective analgesia in man without causing addiction and is safe for physicians to prescribe."

The new drug was discovered and developed at the Sterling-Winthrop Research Institute, Rensselaer, N. Y., by Dr. Sidney Archer, director of the chemistry division, and a group of colleagues. In early studies, it was discovered that the new compound is a narcotic antagonist which neutralizes the narcotic effects of a drug such as morphine. In addition, it was also found to be a pain killer as strong or stronger than most generally used analgesics.

Following tests in 1963 at the United States Public Health Service Hospital at Lexington, Ky., pentazocine was declared non-addicting by the Committee on Drug

(continued on page 696)

Addiction and Narcotics of the National Research Council.

The NDA submitted to the Food and Drug Administration reports the observations of about 150 clinical investigators in more than 7,000 patients in the United States and Canada. The three copies of the NDA sent to FDA contain 15,000 pages each and are bound in 141 volumes which, together, weigh 450 pounds. The clinical studies were under the direction of Dr. Robert W. Ballard, Winthrop vice-president and director of medical research.

The NDA data show that the new drug provided effective pain relief in over 90 per cent of patients. It was administered by vein, by muscle or subcutaneously to patients of all ages with pain due to many causes. It was found to relieve pain of all degrees—mild, moderate and severe—in people with acute or chronic conditions, the NDA states.

Particular attention was paid to the new drug's effectiveness in treating postoperative pain and pain during childbirth. Some other conditions in which it was used, involving moderate or severe pain, included angina pectoris and other heart ailments, cancer, renal colic, migraine and tension headaches and rheumatoid arthritis.

In addition to Talwin's non-addiction characteristics, the NDA data indicate that it produced relatively few side effects. For example, it was free of hallucinatory reactions usually associated with narcotic antagonists. It showed few of morphine's undesirable reactions, such as severe respiratory depression, retention of urine and constipation. Many patients reported that Talwin had a mild sedative effect, often considered by doctors to be an advantage in very painful conditions. Dizziness was noted in some patients but tended to diminish the longer the drug was given. The incidence of nausea and vomiting was considered low.

The NDA notes that clinicians had no difficulty administering the new potent analgesic with other medicines such as tran-

quilizers, antibiotics, sedatives, antidepressants and cardiovascular drugs.

Upon approval of the NDA by the Food and Drug Administration, Talwin will be manufactured by Winthrop Laboratories and made available to the medical profession.

The NDA covers only the injectable form of the new compound. It has also been developed in tablet form for oral administration, and clinical studies covering this form are under way.

PHOCOMELIA DRUG

George W. Orr, Jr., president of Ames Company, Inc.—a subsidiary of Miles Laboratories, Inc., Indiana pharmaceutical and chemical manufacturer—recently issued the following statement concerning allegations made in the U.S. Senate May 17 by Sen. Russell B. Long (D., La.) on the company's pricing of a diagnostic test which detects the presence of phenylketonuria (PKU) in babies. PKU is a chemical imbalance in the blood that causes permanent brain damage if it is not detected within the first month of a baby's life and treated by diet.

"Unfortunately, Senator Long has received inaccurate and incomplete information regarding the PKU test developed by Dr. Robert Guthrie, University of Buffalo, and marketed by Ames Company," Orr said.

"The following points should be made clear at this time:

"1. Ames does not sell, and has never sold the Guthrie test at \$260 per unit, as Senator Long stated. The price is \$67.71 for a unit that will test 325 babies for PKU—a cost of 20 cents per baby tested.

"2. Ames' cost of producing the Guthrie test is not \$6, as inferred, but has always been several times that figure.

"3. Ames has spent many thousands of dollars in testing, refining and equipping manufacturing facilities to produce the

(continued on page 698)

Depend on low-cost,
low-dosage Prolixin
— once-a-day



Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

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PROLIXIN
SQUIBB FLUPHENAZINE HYDROCHLORIDE

SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB



Squibb Quality—the Priceless Ingredient

PKU test. To date, the company has not recovered its expenses.

"4. Ames agreed to make available, without charge, sufficient material to test 200,000 babies to aid in continuing the testing initiated by the Children's Bureau.

"5. Ames did not obtain and never has obtained a 'monopoly' for the Guthrie test. The contract with Dr. Guthrie expressly recognized the interests of various organizations, including the U.S. Government, and that rights in the test would be subject to the assertion of prior claims.

"6. The request to the Public Health Service asked exclusive marketing rights for Ames only for a limited period. The Public Health Service had already indicated that such an arrangement should include provision for a royalty-free license to the U.S. Government and for use of any state or agency that required the use of the test. They also indicated that, if granted, the exclusive period would be restricted to two years after which any patent would be dedicated to the public. However, no exclusive marketing rights were granted.

"7. Any royalties payable under the contract were to be assigned to charitable and educational organizations.

"Dr. Guthrie brought this test to Ames because of its established prominence in developing PKU testing programs. We believe that Ames has acted in the public interest in further developing a useful test and manufacturing it under high standards of quality control. It was made available as a service item, without expectation of profitable returns," Orr concluded.

DISPOSABLE SIGMOIDOSCOPE

A disposable sigmoidoscope is now available from Smith Kline Instrument Company.

First of its kind, the 'Visiline' Disposable Sigmoidoscope eliminates the unpleasant and time-consuming task of scope cleaning and helps ensure immediate availability of clean, ready-to-use scopes in the office, hospital and clinic.

In addition, the disposable sigmoidoscopes avoid the risk of transferring pathogens from one patient to another.

The 'Visiline' sigmoidoscope and obturator are molded of high-strength, shatter-proof polyethylene. After use, the scope, obturator and eyepiece are disposed of in the original package.

The sigmoidoscope's dimensions are standard: 25 centimeters long and 21 millimeters in diameter. Its lumen is brushed to eliminate glare.

Made for use with the disposable components are two 'Visiline' light systems—a rechargeable system which is ideal for ward use and a plug-in system that operates from any standard electrical outlet.

The rechargeable system consists of a nickel-cadmium battery power supply that gives approximately 35 minutes of light with each charging, distal and proximal light rods and an automatic battery charger that plugs into a standard outlet.

The plug-in system consists of a power supply and distal and proximal light rods. The plug-in power supply contains a miniaturized transformer and has a nine-foot cord with an on-off switch. No separate transformer is needed.

The disposable parts cost between 72 and 95 cents, depending on the quantity purchased. The 'Visiline' rechargeable light system costs \$30 and the plug-in system \$25.

The light systems and quantities of 10, 50, 100 or 500 disposable scopes are available directly from Smith Kline Instrument Company, 1500 Spring Garden Street, Philadelphia, Pa. 19101. Information can be obtained from Department I-10.

BEHAVIORAL REGULATOR

Following a 24-week psychiatric study of 276 geriatric patients in 13 Veterans Administration Hospitals, acetophenazine (Tindal, Schering) "seemed superior in

(continued on page 700)

*"I can't cope any more...
I worry about everything.
I don't sleep well...
wake up tired and irritable."*

When you recognize depression and associated anxiety... consider starting the patient on 'Deprol'

1. 'Deprol' can help lift the mood of the depressed patient.
2. 'Deprol' usually restores normal sleep by relieving the associated anxiety and tension which often cause insomnia.
3. Patients often report and show noticeable improvement within a short period of time.
4. In seven years of clinical use, side effects with 'Deprol' at recommended dosage have been infrequent and usually easily controlled.
5. No incompatibility with other medications has been reported to date. However, the possibility of additive effects should be considered.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

 WALLACE LABORATORIES/Cranbury, N. J.

CD-5194

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure or visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

A DIETARY DRAMA

DIETITIAN'S DILEMMA

Henry T. Ricketts, M.D./chicago

SCENE: Doctor's Office

CHARACTERS: Doctor

Patient (obese, hypertensive, diabetic)

Dietitian

Scene opens with doctor at desk.

Another desk and three chairs at opposite end of stage for dietitian.

Single chair up stage center for patient.

Enter patient. Sits at Dr.'s desk.

Dr.: How do you do, Mrs. Olson?

Pt.: Well, not so good.

Dr.: What brings you here?

Pt.: Well, they say I've got high blood pressure and "di-a-bet-us."

Dr.: Who is "they"?

Pt.: The doctor I've been going to.

Dr.: Did he also say you were overweight?

Pt.: Well, yes, he did, but I've been fat since I was a kid. My husband doesn't like me thin anyway.

Dr.: How long have you had diabetes?

Pt.: About a year that I know of.

Dr.: And the high blood pressure?

Pt.: Oh, quite a few years, I guess.

Dr.: Do you feel well?

Pt.: No, I don't. I'm tired all the time and it's hard for me to get around on account of I'm so heavy.

Dr.: What do you weigh?

Pt.: About 200 I guess.

Dr.: And how tall are you?

Pt.: About five two.

Dr.: What kind of treatment did the doctor give you?

Pt.: Well, he looked me over (that was about a year ago) and found sugar and the high blood pressure and then he said all I needed was a diet and he gave me a list and told me to come back in a month.

Dr.: Did he say what the diet was for?

Pt.: No. He's awful busy and I guess he can't take time to explain things very much.

Dr.: (*To audience*: Somebody has to sometime) How did you get along with the diet?

Pt.: Not very good. In the first place, I didn't understand it, and in the second place, I would have starved to death if I'd followed what I did understand. I didn't get rid of the sugar and I didn't lose any weight.

Dr.: (*To audience*: This is really the way things go sometimes—a printed list, probably 1200 Calories, with no explanation. What can you expect?) So what happened then?

Pt.: He sent me out to the hospital to see a dietitian, and he gave me a slip of paper to show her—I kept it. Here it is (*handing Dr. slip*).

Dr.: (*reading*): “Mrs. Ole Olson. Diabetic diet, low calorie, low sodium, high protein (125 gm.), low fat (30 gm.).” (*To audience*: How would one of you like that assignment? Pity the hospital dietitian who had to carry it out. Probably she didn’t have the courage to phone the doctor and ask him what he meant. She should have.

Are dietitians mice or women? What is a “diabetic diet”? “Low calorie”—how low? The dietitian is not a mind reader. The same for “low sodium”—500 mg? 1000 mg? And how practical is a diet with 125 gm. protein and 30 gm. fat? Most of the high-protein foods have a large complement of fat, too, so that generally a low-fat diet means also a low, or at least a moderate, protein diet. This is the dietitian’s dilemma. We shall see later how she solves it.) *To Pt.*: What did the dietitian do?

Pt.: Well, she took an awful long time to figure it out, and there were a lot of people waiting, so she didn’t have time to explain it much. She gave me a diet sheet and little book about *exchanges* or something like that and told me to read it but I can’t make much out of it. And I still don’t get enough to eat on that diet and I get tired of the same food all the time. I went back to the doctor after a while and said I didn’t like the diet much and he asked me what I wanted. I said more to eat, and especially more milk. I like milk. I drink a glass at each meal and when I go to bed. He said that was all right but not to take too much.

(continued on page 706)

FOR SALE

BELLEVUE PLACE at Batavia, Illinois includes 15 acres of real estate, ideal west side location.

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My Address Is:

My Telephone No. Is:

DIETITIAN'S DILEMMA

(continued)

Dr.: (*To audience*: Isn't it your impression that the patient is not exactly pleased with things? Let's pause a minute and see what is wrong. First, she gets no explanation from the doctor—he doesn't know enough, alas, and is too busy anyway. Then, no explanation from the dietitian—she knows enough but she also is too busy. Next, the patient isn't getting enough to eat. What fat person does, you ask. But let's examine this a little further.)

To Pt.: May I see that diet, please? (*Pt. hands Dr. diet sheets.*) (*To Audience*: Here we are again—the old reliable 1200 Calorie diet!) *To Pt.*: Mrs. Olson, how active are you? Do you do all your own work?

Pt.: I sure do.

Dr.: How many rooms do you have?

Pt.: Eight.

Dr.: All on one floor?

Pt.: No, we've got two floors and a basement.

Dr.: How many in your family?

Pt.: Six—me and my husband and four kids.

Dr.: Do the children help out any?

Pt.: No, the oldest is only ten and she's in school.

Dr.: So you do everything—take care of the kids, get the meals, wash the dishes, make the beds, do the dusting and cleaning, wash and iron the clothes, go to market, shovel the snow and transport all that extra weight up and down stairs all day?

Pt.: Doc, you hit the nail on the head. I do all that and then some.

Dr.: (*To audience*: On 1200 Calories she does this? Nonsense. There she sits, all 200 pounds of her. Her *basal* caloric requirement at 10 Calories per pound, would be about 2000 Calories or a little less. Her *actual* daily requirement, considering her activity, must be at least 50 per cent greater, or 3000 Calories to maintain her present weight. Since she has lost no weight, she must be eating

about this much. A 2000-Calorie diet, then, would melt away this exuberant adipose tissue like butter in the summer sun. But no! She is asked to practically starve on the good old 1200-Calorie diet because 1200 Calories is the diet for fat people of all shapes and sizes. And why was she given 1200 Calories by both the doctor and the dietitian? Because neither of them had the time or the interest to ask her a few simple questions. . . . But wait a minute. Would she stay on even a 2000-Calorie diet?) *To Pt.*: Mrs. Olson, have you tried reducing diets before?

Pt.: Oh yes, but I never had any luck. You see, Doc, I'm awful nervous, and when I'm nervous I just gotta go to the ice box and nibble.

Dr.: What makes you nervous?

Pt.: Oh, I don't know. Everything.

Dr.: Do you have any problems that bother you?

Pt.: W-e-l-l, yes, in a way.

Dr.: Are you happy?

Pt.: (*Bursts into tears*) No, I'm miserable.

Dr.: What's the trouble?

Pt.: My husband drinks and he beats me and he treats the kids something awful and I can't do anything about it.

Dr.: (*To audience*: I am convinced that in a very large portion of cases, obesity has its origin in emotional disturbances, and often enough the nature of the disturbance is not as apparent as it seems to be here. We shall, of course, give this patient a diet, we shall explain it to her; and we shall encourage her along the difficult road of weight reduction. But sometime, after we get to know her better, we may call in the social worker and perhaps the psychiatrist to help in solving her domestic problems. It is safe to predict that, until these are resolved at least to some degree, diet therapy is going to be less than fully successful. . . . Meanwhile, let us look further into the diet she has been given. You remember that the doctor wanted her to have 125 gm. protein and 30

gm. fat. With the fat allowance so low, it would be necessary to prescribe some sort of protein supplement, and what the dietitian did was to give her a low sodium, skim milk powder.) *To Pt.:* How did you get along with this milk powder, Mrs. Olson?

Pt.: I couldn't take it, Doc. It tasted terrible, and it was too expensive.

Dr.: (*To audience:* The dietitian did her best to follow the doctor's unrealistic prescription—high protein, low salt, etc. But then what does the doctor do? He puts the salt right back into the diet when he tells the patient, on her return visit, that she can drink ordinary milk "as long as she doesn't take too much." How is that for co-operation between doctor and dietitian? And as for confusing the patient, what could be more effective?)

To Pt.: Mrs. Olson, you have two conditions which are made worse by your being too heavy. One is high blood pressure and the other is diabetes. Both are made worse by eating too many starches and sweets and also by eating too much food of any sort, though I must say I believe you need more than the doctor has prescribed for you. I would like to give you a new diet, but two things come first. I want to examine you now, and then I want you to go home, eat what you usually do, and keep a complete, accurate record of everything that passes your mouth—not only what *kinds* of food but also *how much*—ounces of meat, glasses of milk, cupfuls of vegetables, and so on. At the end of a week, you will come back to see our dietitian. She can tell from your record what kinds of food you like, and she and I together can tell what changes need to be made in your diet. I'd like to have you meet her now. (*calls Miss Goodman. Enter Miss G. [pretty]*) Mrs. Olson, this is Miss Goodman. She and I work very closely together. (*To*

(continued on page 708)

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DIETITIAN'S DILEMMA

(continued)

audience: Do you blame me?)

Pt. and Miss G. *(together)* : How do you do?

ONE WEEK LATER

Doctor at desk

Enter PATIENT

Dr.: Good morning, Mrs. Olson. How are you?

Pt.: I feel better, Doc, since talking to you. I don't know whether you're any good otherwise, but at least you listen to me, which is more than anyone else has done.

Dr.: I see you have your food diary with you. Let me call Miss Goodman. *(calls Miss Goodman. Enter Miss Goodman)*

Dr.: Miss Goodman, you remember Mrs. Olson. She has diabetes and hypertension and, of course, she is much overweight. I wish you would go over her food diary and see what she ordinarily eats. She has had great difficulty in following diets before, possibly because no one has bothered to find out what her food habits are. We will have to make some changes, no doubt, especially in total calories. She is very active, has a large house and a big family and does all her own work. I think she would lose weight very well on a 2000-Calorie diet, and I would suggest something like carbohydrate 200 gm., protein 100 gm., and fat 90 gm. The sodium should be low but not extreme, say 1000 mg. per day. Will you see me after you have interviewed her so that we can iron out any difficulties you may encounter?

Dtn.: Yes, doctor. Will you come with me, Mrs. Olson? *(gracious and friendly)* May I take your packages and coat? It's warm in here. I'll put your coat on the extra chair and we can sit at the table. *(Patient—nervous, anxious, drops purse—sits on edge of chair stiffly.)*

Dtn.: *(To audience: I don't think she trusts me. Maybe she thinks I'll be the one to take food away from her. Or per-*

haps she thinks I might be critical of her. I'll have to make her understand that I'm sincere in wanting to help her.) *To Pt.*: How have things been working out for you this week, Mrs. Olson?

Pt.: Not very good. I want to apologize for my food diary. I don't know if you can read it. I don't generally eat this way. I've been so busy this week going to the hospital every day to see my aunt, who lives next door. She has diabetes, too.

Dtn.: I can understand that you must have been extremely busy and upset. Is your aunt better?

Pt.: She isn't getting along well at all. Her diet is terrible. She gets so hungry I have been bringing her stuff from home. She says everything she likes is taken away and what's left doesn't taste good, so I take her diabetic cookies and limp bread (*patient*

warms up). I have a real good recipe and it works out fine.

Dtn.: (*To audience*: I can't criticize now or she won't tell me another thing. She's defensive enough as it is. But what a break! Here is her aunt, with about the same kind of trouble she has. Maybe, if I talk about the aunt, I'll indirectly learn something about *the patient's* feelings about a low-caloric diabetic diet and about her cooking.) *To Pt.*: How do *you* feel about your aunt's diet, Mrs. Olson, the one she is getting in the hospital, I mean? Do *you* think it is so bad?

Pt.: Oh, some things are all right, but they aren't cooked the way I'd cook 'em at home.

Dtn.: Tell me a little more about what you mean.

Pt.: Well, take yesterday. She had some roast veal, and it was so dry she
(continued on page 710)

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DIETITIAN'S DILEMMA

(continued)

couldn't eat it. I always cook our veal in sour cream. I brown it first in $\frac{1}{2}$ cup butter and then I add 1 cup sour cream and $\frac{1}{2}$ cup cream cheese. It's wonderful. We love it.

Dtn.: It sounds mighty tasty. I can understand how your aunt must feel about having veal without sour cream gravy.

Pt.: (*breaking in and warming up still more.*) I've got a wonderful recipe for sour cream fried trout, too. We're Swedish you know—and we eat lots of fish. You'd love it, too.

Dtn.: (*To audience:* I won't enlarge on the wonderful account she gave of her recipes for plum-rum soup, cheese and cream tarts, fresh hot Swedish coffeecake, and coffee between meals. It is obvious that Mrs. Olson literally loves food and spends a great deal of time at her aunt's house sharing her joys and sorrows over coffee and Swedish coffeecake.) *To Pt.:* Tell me a little more about your aunt. Is she overweight?

Pt.: Oh yes, we're all heavy—even the children. The only ones who aren't overweight in our families are our husbands. My uncle says he likes us that way and not to worry about a diet. It's not the food that makes us fat, anyway. He says he eats the same as we do and he's skinny, so it *can't* be the food. He told my aunt and I just to leave out sugar and forget about the diet. It makes sense to me, too, because I couldn't lose anything on those diets I had.

Dtn.: How does your husband feel about it?

Pt.: He agrees with my uncle. He doesn't like to hear about diets either.

Dtn.: (*To audience:* This confirms studies which show that "Ninety-nine per cent of the time we are not treating the patient; he is being treated by himself or his family or friends." Obviously, her previous diets were neither understood nor followed. We'll have much better luck if we learn

something of the patient's customary food habits and prescribe a diet with as few modifications as possible. For this purpose nothing beats a food *diary*. It's a lot better than a food *history*.) *To Pt.:* You must have found it pretty difficult to keep a food diary and do all the extra cooking and visit your aunt at the hospital so often.

Pt.: Yes, it was hard. I guess I didn't write everything down, but I did the best I could.

Dtn.: I'm sure you did. (*Pt. hands food diary to dietitian; resumes stiff posture on edge of chair, showing fear and concern about what the dietitian might say.*)

Dtn.: I see you have some fine foods here and good variety. Some milk is excellent. Do you always have four glasses a day?

Pt.: Yes, I really like milk each meal—and especially at bedtime. It makes me sleep better. Sometimes I like a slice of limpa with it, too.

Dtn.: I see you have Swedish meat balls and fish dishes pretty regularly. How large are your servings? (*Dtn. shows food models.*)

Pt.: Our meat balls are about half that size. I don't eat very much. I can't chew other kinds of meat. My teeth don't fit very good.

Dtn.: I see you like fresh fruits and raw vegetables.

Pt.: Yes, I like raw things, but I can't chew them very much either. I tried this week though. The doctor said I should eat a lot of them if I wanted to lose weight. It didn't help though.

Dtn.: There are a number of cooked vegetables here, too. How do you season them?

Pt.: I use a lot of dill weed, nutmeg, parsley, mint, capers, lemon juice, salt, and sometimes I use a little wine.

Dtn.: How much butter do you use?

Pt.: Well, we buy about four pounds a week for cooking, and I use some margarine, too. They say corn oil margarine is good for you and it

doesn't make you fat the way butter does.

Dtn.: (*To audience*: Oh-Oh! This means that, with butter and margarine and the sour cream and cream cheese, she may be having between 500 and 1000 Calories a day in this kind of fat alone.) *To Pt.*: These herbs and spices must give a delicious flavor to your vegetables. Actually the butter and salt would be the major items you'd need to leave out, and it is quite likely that you will find plenty of herbs and spices to substitute for the flavors from butter and salt. Lemon juice is an excellent substitute for salt really. Do you think you could do this?

Pt.: (*dubious*): I wonder if food would taste good?

Dtn.: Perhaps it would be easier than you think to season things. We do have some cookbooks containing a number of suggestions for seasoning without butter or salt. We can look through them for ideas. Would you like to do that?

Pt.: I guess I could if it's really important for my health. I feel pretty good though—just tired.

Dtn.: You said earlier that you were too busy to write everything down. What kind of thing did you leave out?

Pt.: Mostly between-meal things I guess—like coffecake and coffee, sometimes limpa bread. I don't use sweet things. Oh, and I often toast the bread—this doesn't make it so fattening.

Dtn.: (*To audience*: Another old wives' tale.) *To Pt.*: Thank you, Mrs. Olson, you have been very helpful. If you'll excuse me I'll talk with the doctor. Then we can begin planning some meals for you.

Conference with doctor.

Dtn.: Basically Mrs. Olson has an excellent core diet of . . .

Dr.: (*interrupting*): What do you mean—a "core" diet?

Dtn.: Oh, doctor, you know what I mean. Somewhere, buried in all these things

(continued on page 712)

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DIETITIAN'S DILEMMA

(continued)

that she eats, there are some basic foods that she likes and that are needed—needed by anyone. We're lucky that this adds up to about what you ordered, if she leaves out the extras—C-200, P-70, F-100 grams, about 2000 Calories.

This isn't quite the amount you suggested. She says she doesn't want more meat than she is eating now. In part I think because she finds it difficult to chew. The chief source of extra calories is in butter, sour cream, and cream cheese which she uses generously in cooking.

I think we might be able to help her change some of her ways of cooking and her recipes if we see her once a week for a while. However, she will need more motivation. She spends a lot of her time with her uncle and an aunt who has diabetes. The uncle has told them both that it isn't food that makes them fat. He eats the same as they do and he is skinny, therefore, "it *can't* be food." None of them understands just how food fits into the treatment for diabetes. She says she feels all right—just tired.

Dr.: (*To audience*: I think we can end our little play at this point. You have observed that close personal communication between doctor and dietitian—*conversation*, not just little notes passed back and forth—has led to an understanding of what the patient's food habits are, has shown us a number of false concepts she has about food and its relation to obesity, and has enabled us to prescribe a *reasonable*, weight-reducing diet simply by modifying, not drastically altering, her own self-selected diet.

It will be my duty to explain to the patient that one gets fat only by eating more than he really needs, that (despite her family's notions) one loses weight only by eating less than he really needs or is presently taking, that her diabetes may come under control with loss of weight alone and without taking either pills or insulin, that carbohydrate will have to be limited because she is not making enough insulin in her pancreas to handle normal amounts, that her blood pressure may come down likewise, that corn oil is just as calorific as butter, that toasting bread does not take away any calories, etc. The dietitian will collaborate with me in reinforcing many of these admonitions.

It will also be my duty to support the patient in her problems with her alcoholic husband, and indeed, to interview him in order to explain how his behavior is affecting his wife's health. Undoubtedly he needs some counseling himself.

Meanwhile, the dietitian will take the patient in hand, explain the Exchange system of dietary calculation, and then go directly to the planning of meals in accordance with the dietary prescription. Please note that the dietitian is free to negotiate with the patient about the diet. Minor changes from the prescription are of little importance. The patient is much more likely to adhere to the diet if her tastes are considered to some degree and especially if she is made to feel that she is actually participating in its planning.

Finally, the patient will return to the dietitian oftener than she does to me. It is less expensive and probably will do her more good.)

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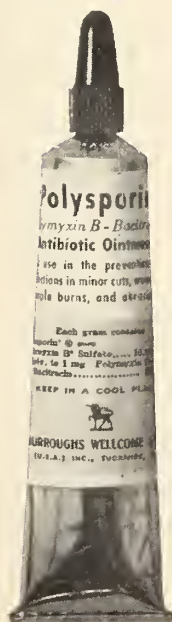


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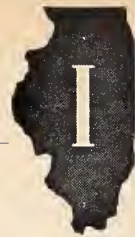
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(Due to the large volume of news reported as annual meetings, abstracts and features elsewhere in this volume, the News and Announcement Section for June has been reduced to one page. It will return to normal length in the next issue.)

Grants

The Deafness Research Foundation has awarded fourteen direct grants for ear research projects to scientists in universities and otologic laboratories throughout the United States, it was announced here recently by Mrs. Hobart C. Ramsey, founder and president.

Seven renewals of prior grants for research projects in progress were also announced, bringing the total expenditure to more than \$200,000 for the past six months. Of this amount, \$100,000 came from the Alfred P. Sloan Foundation, which recently announced an appropriation of \$258,000 to The Deafness Research Foundation, the largest sum ever given for ear research by a private source. The Foundation's grants in seven years of operation now total more than one million dollars.

In addition to its support of research into the causes and means of prevention of deafness and other ear disorders, The Deafness Research Foundation has developed the Temporal Bone Banks Program for Ear Research.

Presently, in 37 Temporal Bone Bank Laboratories across the country, scientists are studying inner ear structures together with the donor's lifetime medical and hearing records to shed light on the mysteries of the inner ear.

Three medical schools will each receive a \$100,000 award to support a section of Clinical Pharmacology, according to William Creasy, President of The Burroughs Wellcome Fund of Tuckahoe, New York. These

awards, which run for five years, are given to support a "Burroughs Wellcome Scholar in Clinical Pharmacology" in each medical school.

This year's recipients are Southwestern Medical School of the University of Texas on behalf of Dr. J. Richard Crout, the College of Medicine of the State University of Iowa on behalf of Dr. William R. Wilson and The School of Medicine of Vanderbilt University on behalf of Dr. John A. Oates. These three awards bring the number of Burroughs Wellcome Scholars in Clinical Pharmacology to nine since the program was started in 1959.

The purpose of the Clinical Pharmacology Awards is "to assist medical schools in providing laboratories and clinics where students may learn under a first-class scientist and teacher to apply basic scientific knowledge and techniques to the study of clinical pharmacology, and to develop thereby clinical investigators who are capable of evaluating critically the therapeutic efficacy and mechanisms of actions of drugs."

The Burroughs Wellcome Fund Clinical Pharmacology Awards, which now total \$900,000 represent a pioneering effort in the field of clinical pharmacology. They have helped to spark further development of both public and privately supported programs and train more scientists and clinicians to study the metabolism and action of drugs. In this way, more knowledge will become available on the efficacy and safety of drugs for human use.

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OBITUARIES

Arthur E. Baker*, Peoria, died April 2, aged 78. A graduate of Northwestern University Medical School in 1914, he had been resident physician of the Buehler Memorial Home for 31 years and retained his board membership although he retired in 1964. He was a member of the Fifty Year Club of ISMS.

William F. Chambers*, Peoria, died April 19, aged 45. A graduate of the University of Illinois College of Medicine in 1942, Doctor Chambers had been chief of obstetrical & gynecological service of Proctor Hospital since 1952.

Thomas E. Cherry*, Cowden, died April 3, aged 93. In 1899 he was a graduate of Barnes Medical College, St. Louis. He was an emeritus member and a member of the Fifty Year Club of ISMS.

John C. Dwyer, Jr.*, Harvey, died May 3, aged 49. He was a graduate of the University of Illinois College of Medicine in 1945 and he was a member of the American Academy of General Practice.

Jacob Faltermayer, Chicago, died April 12, aged 89. In 1910 he was a graduate of the Chicago College of Medicine & Surgery.

Arthur H. Fisher*, McAllen, Texas, formerly of Chicago, died April 13, aged 79. A graduate of Rush Medical College in 1912, he was a member of the Geriatric Society. He was also an emeritus member of ISMS.

Jay McKinley Garner*, Winnetka, died April 18, aged 71. A graduate of Rush Medical College in 1921, he served on the staff of Evanston hospital from 1926 until his retirement in 1962. He was attending physician in internal medicine for 11

years and also taught at Northwestern University Medical School.

John M. Gillespie*, Marion, died April 13, aged 88. In 1905 he was a graduate of Barnes Medical College, St. Louis.

Joseph Jonofsky, Chicago, died February 6, aged 60. In 1932 he was a graduate of the University of Illinois College of Medicine and he specialized in internal medicine.

William L. LeBoy*, River Forest, died May 5, aged 84. A graduate of Bennett Medical College in 1905, he practiced medicine for 60 years. He was on the staff of Garfield Park Community hospital for over 50 years, where he died. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Joseph T. Maher*, Danville, died April 19, aged 60. In 1928 he was a graduate of Washington University School of Medicine, St. Louis. Doctor Maher, retired in 1961, was former chief of tuberculosis service and personnel physician at the V.A. Hospital and former medical director of the Vermilion County Tuberculosis Hospital & Dispensary.

Silas W. Williams, San Francisco, California, formerly of Walpole, died March 11, aged 87. A graduate of St. Louis College of Physicians & Surgeons in 1907, he practiced medicine in Hamilton County until World War I when he began his career in military medicine. He retired as a Colonel in the Army in 1945. He had served on military posts both in Europe and the U.S. and during World War II he taught military medical personnel at the University of Washington, Washington State.

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